



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

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

Volume 5: Children in youth detention  
Book 1

August 2023

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

**Volume 5**  
**Children in youth detention (Book 1)**

**The Honourable Marcia Neave AO**

President and Commissioner

**Professor Leah Bromfield**

Commissioner

**The Honourable Robert Benjamin AM SC**

Commissioner

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# Introduction to Volume 5

In accordance with the Order establishing our Commission of Inquiry, Volume 5 examines the Tasmanian Government's responses to allegations of child sexual abuse at Ashley Youth Detention Centre since 2000. Any references to the Centre's predecessor—Ashley Home for Boys—are solely to cast light on the present system of youth detention.

Ashley Youth Detention Centre is Tasmania's primary dedicated youth detention facility. However, it is not the only facility where children and young people are held in detention in Tasmania. Some adult custodial facilities have been declared to be youth detention centres, including Hobart Reception Prison, Launceston Reception Prison and Risdon Prison.<sup>1</sup> Children and young people can also be transferred from Ashley Youth Detention Centre to an adult prison facility.

While we have not inquired into the treatment of children and young people in adult custodial facilities, many of the issues raised in this volume will also have implications for children and young people in those settings. We encourage the Government to consider our recommendations broadly and approach implementation consistently in relation to children and young people in all custodial settings in Tasmania.

Under the *Youth Justice Act 1997*, the Secretary of the government department with responsibility for Ashley Youth Detention Centre is designated as the 'guardian' of children in detention and is responsible for the security and management of detention and for the safe custody and wellbeing of detainees.<sup>2</sup>

There are high rates of sexual abuse for children in detention, making children in detention among the most vulnerable in our community to this abuse.<sup>3</sup> We know children in detention have often experienced trauma, maltreatment and significant development disorders, all of which are risk factors for abuse.<sup>4</sup> There is also an over-representation of Aboriginal children in detention. Aboriginal children experience heightened vulnerability because of the impacts of intergenerational trauma stemming from the damaging legacy of colonisation.<sup>5</sup> The already substantial barriers to disclosing sexual abuse are heightened for children in detention, who some in the community perceive as 'criminals'.<sup>6</sup>

The 'closed' nature of detention environments compounds these vulnerabilities, creates opportunities for abuses of power and heightens the risk of child sexual abuse. Risk factors for child sexual abuse in detention include:

- the deprivation of children's liberty and a lack of privacy
- isolation and disconnection from friends, family and community
- lack of access to trusted adults

- the power imbalance between adult staff and detained children
- the use of rigid rules, discipline and punishment
- the lack of voice afforded to children
- cultures of disrespect for, and humiliating and degrading treatment of, children
- strong group allegiance among management.<sup>7</sup>

Ashley Youth Detention Centre is located in an area that is geographically remote from Hobart, Launceston, Burnie and Devonport, resulting in the isolation of many children and young people from their homes, families, communities and services. This location meant that the widespread and systematic abuse experienced by some children and young people at the Centre occurred away from the public eye. This volume contains harrowing details not only of allegations of child sexual abuse, but of a culture of unauthorised use of force, restraints and isolation and of belittling and humiliating behaviours allegedly used to dehumanise children and young people in detention.

For more than two decades, concerning incidents and risks to children at Ashley Youth Detention Centre have populated the media.<sup>8</sup> The Tasmanian Government has been alerted to the risk of sexual abuse for children in state care on many occasions, including through the findings of previous reviews of the Tasmanian statutory child protection and out of home care systems, the National Royal Commission report, and many internal and external briefings, reviews and reports into Ashley Youth Detention Centre. Our Commission of Inquiry uncovered a pattern of the Government either ignoring reviews and recommendations, or implementing them without achieving meaningful or sustained reform.

We know there are current and former staff at Ashley Youth Detention Centre who care about and are committed to supporting the wellbeing of children. We also know that some staff felt, at times, fearful and unsafe in their work and insufficiently equipped or trained to deal with the distressing and complex behaviours exhibited by some traumatised children and young people. Despite these challenges, we found former detainees who spoke positively about the members of staff who were not complicit in harmful and abusive behaviours.

We acknowledge these hardworking and dedicated staff at Ashley Youth Detention Centre who performed to the best of their ability in a highly complex, fraught and difficult environment to meet the needs of children detained at the Centre and to act in their best interests. We appreciate and acknowledge the impact and toll our Inquiry has had on Ashley Youth Detention Centre staff. However, it was critical to the wellbeing of children in detention that we engaged in a comprehensive examination of the conditions at the Centre.

Our examination of Ashley Youth Detention Centre drew from multiple sources of information. We visited the Centre and reviewed thousands of documents. We heard from numerous victim-survivors, who described similar experiences of abuse over different periods—similar to each other and similar to the records we reviewed of critical incidents and complaints. We thank these victim-survivors, without whom we would not have understood patterns of abuse. We recognise others from whom we did not hear personally.

We also heard from former and current staff, and others with experience of the Centre. Some shared their previous efforts to change what was occurring at the Centre, and their deflation and frustration as problems persisted. We are indebted to all those who took the time to share information with us, sometimes at a personal cost. Without some of these witnesses, particularly whistleblower Alysha (a pseudonym), we would not have known where to focus our Inquiry.<sup>9</sup>

This volume contains three chapters. In Chapter 10—Background and context: Children in youth detention—we describe the background to and context for, our examination of Ashley Youth Detention Centre. We discuss the risks of child sexual abuse in youth detention and the National Royal Commission’s recommendations to address these risks. We then give an overview of Ashley Youth Detention Centre, including the demographics of children in detention and the Centre’s management, staffing, operations, key processes and oversight mechanisms. We also summarise previous reports and inquiries into Ashley Youth Detention Centre.

In Chapter 11—Case studies: Children in youth detention—we present seven case studies that examine:

- the nature and extent of allegations of child sexual abuse at Ashley Youth Detention Centre
- allegations of harmful sexual behaviours and the responses to those behaviours
- unauthorised use of isolation as a common practice
- the excessive use of force
- two examples of how complaints from staff and detainees were managed
- the Tasmanian Government’s response to allegations of child sexual abuse by staff at the Centre.

These case studies illustrate the scale of systematic abuse and an entrenched culture that threatened the safety of children and young people in detention.

In Chapter 12—The way forward: Children in youth detention—we make recommendations to improve the safety and wellbeing of children in detention. Our recommendations are directed at addressing the legacy of abuse at Ashley Youth

Detention Centre, achieving lasting cultural change in youth detention, reducing the number of children in detention, addressing the over-representation of Aboriginal children and creating a child-focused detention system where practices such as isolation and the use of force are minimised. We also recommend changes to improve responses to harmful sexual behaviours in youth detention and to strengthen complaints and oversight mechanisms to reduce the risks of child sexual abuse.

## **A note on language**

Children and young people in detention are referred to in different ways, including ‘detainees’ and ‘residents’. In our report, we refer to ‘children and young people in detention’ or ‘detainees’ because we consider this terminology more accurately reflects their situation. Similarly, we tend to refer to ‘cells’ or ‘rooms’ rather than ‘bedrooms’ at Ashley Youth Detention Centre.

In this volume, we use the term ‘Department’ to mean the department responsible for youth detention at the relevant time. From 2000 to 2018, this was the Department for Health and Human Services.<sup>10</sup> From 2018, it became the Department for Communities (also referred to as Communities Tasmania).<sup>11</sup> In October 2022, the department responsible for youth detention changed to the newly formed Department for Education, Children and Young People.<sup>12</sup> Where there is potential ambiguity, we use the full name of the relevant department.

# 10 Background and context: Children in youth detention

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## 1 Introduction

In this chapter, we discuss the risks of child sexual abuse in youth detention and the recommendations made by the National Royal Commission in response to these risks. We outline the international and domestic rights of, and obligations to, children and young people in detention.

We then focus on Tasmania's primary dedicated youth detention facility, Ashley Youth Detention Centre, discussing the demographics of children and young people at the Centre; its management, staffing and operations; its key processes in managing children and young people's behaviour and responding to incidents; and the oversight mechanisms for youth detention.

Finally, we discuss previous reports and inquiries into Ashley Youth Detention Centre and identify common themes that emerged from these reports, including concerns about the treatment of children and young people in detention. We end with some conclusions about a system in crisis.

## 2 Risks of child sexual abuse in youth detention

It is common for children and young people who have contact with the justice system, including those who are held in detention, to have experienced prior trauma.<sup>13</sup>

International research shows that many incarcerated children and young people have grown up in the most disadvantaged families, neighbourhoods and communities.<sup>14</sup> Also, many have been exposed to violence, abuse or neglect in their immediate social environment, resulting in the involvement of child protection authorities.<sup>15</sup>

Elena Campbell, Associate Director, Research, Advocacy and Policy at the Centre for Innovative Justice in Melbourne, told us that ‘adverse childhood experiences’, including childhood sexual abuse and neglect, are key drivers of children and young people’s contact with the justice system.<sup>16</sup> Ms Campbell noted that more than two-thirds of children in youth justice environments in Victoria had experienced violence, abuse or neglect. Research in Queensland and Western Australia has found that three-quarters of young people in contact with the justice system have experienced some form of non-sexual abuse.<sup>17</sup>

It is also common for children in out of home care to have contact with the youth justice system. The ‘crossover’ from out of home care to youth detention can be driven by multiple factors, including exposure to peers with difficult behaviours, inadequate carer training, poor placement decisions and poor interagency relationships—all of which create volatile living environments and increase the likelihood of police intervention.<sup>18</sup> Under such conditions, events such as ‘underage drinking, smoking marijuana or smashing the wall out of frustration’ that could be minor in nature will often result in children being transferred from the out of home care system into the criminal justice system.<sup>19</sup>

Research shows that prior maltreatment affects the psychological, emotional and social wellbeing of children and young people in detention and places them at greater risk of ongoing abuse, including sexual victimisation and assault, while in detention.<sup>20</sup> The National Royal Commission noted that the combination of several factors may increase the risk of child sexual abuse in youth detention.<sup>21</sup> Also, the longer a child or young person stays in detention, the greater the likelihood they will experience sexual victimisation.<sup>22</sup>

Recent international studies have estimated that about 7 per cent of girls and 6 per cent of boys in detention are exposed to sexual victimisation by peers or staff.<sup>23</sup> Studies have also concluded that children and young people who identify as LGBTQIA+ are at greater risk of victimisation than their peers.<sup>24</sup>



Youth justice centres are characteristically highly controlled institutions that are largely closed off from the outside world; they are also hierarchical institutions, with significant power disparity between staff and the young people who are detained. In ‘total’ or ‘closed’ institutions, such as youth detention centres, there is a greater risk that children or young people are dehumanised and that staff adopt attitudes and practices of punishment and control.<sup>25</sup> These factors, in turn, increase the risk of, and opportunities for, the sexual abuse of children and young people.<sup>26</sup> Also, as researcher Eileen Ahlin explains:

Unlike adult jails and prisons, where guards and inmates are above the age of 18, youth are poised to experience exploitation or coercion that could be cloaked behind the guise of guardianship.<sup>27</sup>

The National Royal Commission outlined numerous factors that increase the risk of child sexual abuse in contemporary detention environments and, more specifically, youth detention facilities. These factors may be environmental, operational or cultural, and include:<sup>28</sup>

- the deprivation of liberty and lack of privacy
- blind spots in building design that impede the visibility of children
- inadequate supervision of staff and inadequate oversight of day-to-day operations
- isolation, lack of access to a trusted adult and disconnection of young people from family, friends, community and culture
- power imbalances between staff and children, including staff control of the day-to-day lives of children
- the use of strict rules, discipline and punishment
- cultures of disrespect for, and humiliating and degrading treatment of, children
- cultures where children’s voices are not encouraged, and their welfare is not prioritised
- group allegiance among staff and among managers.<sup>29</sup>

We discuss other risk factors for mistreatment of children and young people in detention in Chapter 12.

As part of our Inquiry, we commissioned researchers to engage with Tasmanian children and young people to explore how they perceived safety in institutional contexts, including youth detention.<sup>30</sup> Broadly, children and young people identified ‘safe’ institutions as stable and predictable environments marked by the availability of protective adults and peers. Children and young people also associated safety with having some agency over their lives.<sup>31</sup>

On the other hand, the feeling of being ‘unsafe’ in an institution was commonly linked to experiences or observations of bullying, intimidation and violence.<sup>32</sup> Many young people in our commissioned research reported that a major problem with youth detention is the tendency for this environment to be, in the researchers’ words, ‘chaotic, damaged or in disrepair’, lacking privacy and occupied by the kinds of people who would be more, not less, willing to respond to conflict with disproportionate violence.<sup>33</sup>

Some young people with experiences of detention also told our researchers that separating younger children in detention from older ones would be an effective way to keep young people safe, but this did not occur in detention facilities as a matter of course.<sup>34</sup> As one young person put it:

Why put the 13 year old up with all the fucking people that are like 17 and 18 years old? But now they’ve got one little 13 year old in there. He’s trying to get up with all of us and then he says something wrong, and he ends up getting himself bashed.<sup>35</sup>

Another young person recalled his attempts to avoid victimisation at the hands of other young people in detention by asking staff for help. He said:

I told them multiple times over the years [about being physically assaulted], not just when I was younger ... [that] I’ve been bashed by lots of people ... They’re like, ‘You’ve been a cunt to us, so why should we protect you?’ ... That’s what really pissed me off with the whole centre. They’re supposed to be there, worrying about our safety, but they’re sitting there, and they let us get bashed and stuff. And they sit there and watch you get bashed; they laugh about it. They say “Oh, I reckon you won that fight” or “he won that fight.” What the fuck’s that shit? That’s wrong!<sup>36</sup>

In other instances, some young people spoke about being assaulted by staff members, often in the context of being restrained or after a critical incident:

I had a few restraints, because I was young, back then I was having fun. Got restrained a heap of times. Got taken to my room. I got bashed multiple times by the staff and just thrown around. Obviously, they had to restrain me, but they’re trained to restrain people in a certain [way] like ... Not sit there and lay knees into you and that, and hit you in the back of the head. And there have been times where they’ve just stripped me of all my clothes and left me in my room and that.<sup>37</sup>

One young person gave the following account of his treatment by staff in detention:

And even if I had, they’re supposed to put me in a [cell with a camera] and not strip me of me clothes. But they done that anyway. And that was really awkward, having three blokes, they’re looking at you, why? You’re young, naked, standing there. And then making jokes, saying, “Oh, you’ve got a little one, there.” And I’m like sitting there, bawling my eyes out, because I’ve just been fucked up and I’ve just gotten my clothes stripped off, full invasion of your privacy.<sup>38</sup>

The research we commissioned also identified that some young people who have been detained have experienced or perceived barriers to raising concerns when they were mistreated. These barriers included a fear of retaliation, a reluctance to break the

time-honoured prisoner code (sometimes referred to as ‘argot rules’) against ‘snitching’, a lack of knowledge about or access to complaints processes, staff discouragement of making formal complaints and doubts about the confidentiality of any complaint made. Some young people interviewed also felt powerless to challenge staff members’ versions of an event. As our commissioned research reported:

One young person in youth detention described being searched by workers who used significant force that intentionally caused him pain. After saying he would complain about what had happened, the worker replied “Go on do it. No-one is going to believe you”.<sup>39</sup>

These excerpts offer a small but significant insight into how youth detention environments can place children and young people at risk of abuse.

### 3 National Royal Commission

Volume 15 of the National Royal Commission’s Final Report focused on institutional responses to child sexual abuse in detention, particularly youth and immigration detention. The National Royal Commission highlighted that the Australian Government, as a party to the United Nations Convention on the Rights of the Child, was responsible for taking ‘all appropriate measures to protect children from all violence, injury, or abuse, neglect or negligent treatment and maltreatment or exploitation, including sexual abuse’.<sup>40</sup>

The National Royal Commission found that ongoing scrutiny was required for:

- the physical environments of youth detention facilities
- strip searches in detention
- ensuring young people have contact with trusted adults while in detention
- the institutional culture and staffing of youth detention facilities
- the needs of vulnerable groups of children in detention
- complaints handling and reporting processes for child sexual abuse in detention
- preventive monitoring of youth detention facilities
- independent oversight of detention facilities.<sup>41</sup>

The National Royal Commission made 10 recommendations in its volume on youth detention for implementing the Child Safe Standards; providing expertise in preventing and responding to child sexual abuse as part of Australia’s commitment to ratify the Optional Protocol to the Convention against Torture (discussed in Section 4); reviewing building and design features and relevant legislation, policy and procedures to create

a safer physical environment; strategies to respond to children's different needs, including the cultural safety of Aboriginal children in youth detention; supporting and training for staff; improving complaints handling systems; and independent oversight of youth detention.<sup>42</sup> The National Royal Commission also made several observations about improving the safety of children and young people in youth detention. These included:

- ensuring a safer physical environment for children in youth detention by introducing closed-circuit television systems, body-worn cameras and electronic systems that monitor staff movements, noting also the need to protect the privacy of children<sup>43</sup>
- ensuring clear articulation of the circumstances in which a child can be strip searched, the process for conducting searches, and training for staff and children on what is appropriate and inappropriate when conducting strip searches<sup>44</sup>
- providing therapeutic treatment to sexual abuse victim-survivors in youth detention<sup>45</sup>
- providing adequate support and training to staff, including aiming to change attitudes and behaviours<sup>46</sup>
- avoiding issues regarding poor workforce retention, a casual workforce, staff feeling unsafe and unsupported in a high-pressure environment, a failure to maintain professional boundaries, and poorly defined and articulated roles and responsibilities.<sup>47</sup>

The National Royal Commission also noted that improving institutional responses to child sexual abuse requires changes to reporting and information-sharing processes to ensure:

- making a complaint is accessible and free from backlash for children and young people through confidential and unrestricted external channels<sup>48</sup>
- allegations of staff misconduct are reported to child protection authorities and police by heads of institutions<sup>49</sup>
- records relating to child sexual abuse are held for at least 45 years<sup>50</sup>
- internal monitoring and evaluation, as well as external and independent oversight, is in place to ensure compliance with policies and procedures.<sup>51</sup>

Importantly, the National Royal Commission indicated that children are safer in community settings rather than in closed detention settings.<sup>52</sup>

The Tasmanian Government's most recent Annual Progress Report and Action Plan in response to the National Royal Commission reports that the implementation of many of these recommendations is underway.<sup>53</sup> We explore the need for further reform in Chapter 12.

## 4 Legislative and other obligations when detaining children and young people

Children and young people in detention have rights that are set out in international and domestic law. Operators of youth detention centres also have duties and obligations, set out in those same laws. These rights and obligations are supported, explained or expanded on in various international and domestic standards and policies produced by governments, child advocate groups and statutory watchdogs.

In this section, we briefly outline the key international and national standards, and then focus on Tasmanian legislation and standards relevant to youth detention. As well as legislation and standards, there are departmental policies and procedures relevant to youth detention. These policies and procedures aim to give effect to obligations under the *Youth Justice Act 1997* ('Youth Justice Act') and to reflect some of the broader expectations established under international and domestic frameworks. We discuss these policies and procedures throughout Chapter 12.

The United Nations Convention on the Rights of the Child is the key international instrument setting out the rights of children and young people, including their rights in detention.<sup>54</sup> This Convention provides an international standard against which the operation of youth detention centres in Australia can be considered and assessed. Upholding these rights protects a child or young person in detention from abuse, including child sexual abuse.

Articles 37 and 40 of the United Nations Convention on the Rights of the Child relate explicitly to youth justice. Article 37 states that detaining a child should be a measure of last resort and that, when a child is detained, the detention should be for the shortest appropriate time.<sup>55</sup> Article 40 states that every child who is accused of having infringed penal law should be treated 'in a manner consistent with the promotion of the child's sense of dignity and worth'.<sup>56</sup>

In 2019, the Committee on the Rights of the Child, which is responsible for monitoring the Convention, released General Comment No. 24 on children's rights in the youth justice system. This comment provides more guidance on how the Convention should be implemented.<sup>57</sup>

Other relevant United Nations documents include the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention against Torture'), the Optional Protocol to the Convention against Torture ('OPCAT'), the reports of the Special Rapporteur on the right of all to the enjoyment of the highest attainable standard of physical and mental health ('Report of the Special Rapporteur on the right to health'), the reports of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment ('Report of the Special Rapporteur on torture')

and the United Nations Standard Minimum Rules for the Treatment of Prisoners ('Nelson Mandela Rules').<sup>58</sup> Paragraph 53 of the 2018 Report of the Special Rapporteur on the right to health states that 'the scale and magnitude of children's suffering in detention and confinement call for a global commitment to the abolition of child prisons ... alongside scaled up investment in community-based services'.<sup>59</sup>

OPCAT requires signatory states to establish a system of oversight and regular preventive visits to places of detention by domestic independent bodies known as National Preventive Mechanisms, and to accept visits from the United Nations Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the National Preventive Mechanisms.<sup>60</sup> Tasmania was the first Australian jurisdiction to pass a comprehensive statutory framework on OPCAT.<sup>61</sup> In late 2021, the Tasmanian Parliament passed the *OPCAT Implementation Act 2021* ('OPCAT Implementation Act'). We discuss the role of the oversight body under the OPCAT Implementation Act—the Tasmanian National Preventive Mechanism—in Chapter 12.

Three more United Nations instruments provide important normative principles on how the rights of children should be implemented in the youth justice system. They are the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the 'Beijing Rules'), adopted in 1985; the United Nations Guidelines for the Prevention of Juvenile Delinquency (the 'Riyadh Guidelines'), adopted in 1990; and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (the 'Havana Rules'), adopted in 1991.<sup>62</sup>

These international laws and standards have been implemented to varying degrees at the national level in Australia. The Australasian Juvenile Justice Administrators (now known as the Australasian Youth Justice Administrators) developed the Juvenile Justice Standards (2009), and the Australian Children's Commissioners and Guardians issued principles relevant to the conditions of youth detention and the treatment of detained young people in 2017.<sup>63</sup> Although these standards and principles are not binding, they provide a reference against which youth detention centre operations in Tasmania can be measured.

In Tasmania, the primary legislative instrument governing youth detention is the Youth Justice Act. The key objectives of the Act include to provide for the safe, therapeutic and secure management of young people held in detention centres; to promote their rehabilitation, including through providing appropriate programs; and to support their reintegration with the community.<sup>64</sup> Section 129 of the Youth Justice Act outlines the rights of a child in detention, including the rights to have their developmental, medical, religious and cultural needs met; to receive visitors; and to be able to make complaints. The Act permits the clothed and unclothed searches of detained young

people in some circumstances (sections 25A to 25L), prohibits certain actions in relation to detained young people (section 132) and authorises the use of isolation in some circumstances (section 133).

In 2018, the Tasmanian Custodial Inspector published the *Inspection Standards for Youth Custodial Centres in Tasmania*, which state that they are based on the principles set out in the *Inspection Standards for Juvenile Custodial Services in New South Wales*.<sup>65</sup> The Custodial Inspector monitors youth detention facilities against these standards. More detail on the Custodial Inspector's role is in Chapter 12.

## 4.1 Strip searches

In this volume, we sometimes use the term 'strip search' because this is the phrase victim-survivors used when referring to a search involving any removal of clothing, whether partial or full. However, we note that in the Youth Justice Act and custodial standards and procedures, this practice is commonly referred to as an 'unclothed search', with a distinction drawn between partially clothed and fully unclothed searches. In this section, we refer to 'strip searches', 'fully unclothed searches' and 'partially clothed searches', depending on the context.

The 2015 Report of the Special Rapporteur on torture states that strip searches should not be performed on children without 'reasonable suspicion', but does not define this term.<sup>66</sup> The Nelson Mandela Rules, which cover the treatment of children and adults in prison, state that searches should be conducted in a manner that is 'respectful of the inherent human dignity and privacy of the individual being searched, as well as the principles of proportionality, legality and necessity'.<sup>67</sup> Rule 51 of the Nelson Mandela Rules states that searches should not be used to 'harass, intimidate or unnecessarily intrude' on a prisoner's privacy.<sup>68</sup> The rule also states that records should be kept of any searches, with the record including the reasons for the search, the identities of those conducting the search and any results of the search.<sup>69</sup>

Rule 52 of the Nelson Mandela Rules states that intrusive searches, such as strip and body cavity searches, should be undertaken only if absolutely necessary and conducted in private by trained staff of the same sex as the detainee.<sup>70</sup> It also states that body cavity searches should be conducted by a qualified health-care professional or by a staff member who is not primarily responsible for the detainee's care and who is appropriately trained by a medical professional.<sup>71</sup>

In Tasmania, the Youth Justice Act regulates searches of children and young people in custody, including at Ashley Youth Detention Centre.<sup>72</sup> On 1 December 2022, amendments to the provisions of the Youth Justice Act regarding searches of detained young people came into effect, with amendments including the introduction of sections 25A to 25L.<sup>73</sup>



Previously, section 131(2) of the Youth Justice Act stated that a detention centre manager could submit a detainee to a search for weapons, metal articles, alcohol, articles capable of being used as weapons, drugs or other prohibited items. They could do this as soon as possible after admission or on returning from a temporary leave of absence from the detention facility, and at any other time when there were reasonable grounds to believe that the detainee may have had contraband in their possession, or, in the manager's opinion, it was necessary to conduct the search in the interests of security.

As a result of the 2022 amendments, the references to searches being conducted on admission or after temporary leave have been removed. Searches can now only be conducted where the search officer believes on reasonable grounds that the search is necessary for the 'relevant search purpose' and the type and manner of search are proportionate to the circumstances.<sup>74</sup> Relevant search purposes are set out in section 25F of the Youth Justice Act and include ensuring the safety of the young person or other people, obtaining evidence relating to the commission of an offence or preventing the loss or destruction of evidence, and ascertaining whether the young person has possession of a concealed weapon or drugs.<sup>75</sup>

A search officer conducting a search under the Youth Justice Act must ensure it is conducted, as far as practicable, in a manner that retains the young person's dignity and self-respect; minimises any trauma, distress or harm that may be caused to the young person; is the least intrusive search and conducted in the least intrusive manner necessary; is completed as quickly as is reasonably possible; accords reasonable privacy; does not remove more clothing than necessary; and, if clothing is seized, the young person is provided with adequate clothing to wear.<sup>76</sup>

In determining the least-intrusive type of search that is necessary and reasonable to achieve the 'relevant search purpose', the search officer or relevant authorising officer must consider factors such as the health and safety of the young person, their age, intellectual maturity, sex, sexual or gender identity, religion, disabilities, history and any other relevant matters.<sup>77</sup>

As indicated, the Youth Justice Act does not use the term 'strip search' but instead refers to an 'unclothed search'. The following definition of 'unclothed search' was introduced with the 2022 amendments: 'A search of the youth that requires the youth's torso or genitals to be exposed to view or the youth's torso or genitals, clothed only in underwear, to be exposed to view'.<sup>78</sup> In contrast, a 'clothed search' is defined under the Youth Justice Act as 'a search (other than a body cavity search) of the youth that is not an unclothed search'.<sup>79</sup>

Unclothed searches cannot be conducted in a detention centre under the Youth Justice Act unless they are authorised by the detention centre manager or the Secretary of the Department for Education, Children and Young People, and unless the search



is conducted in line with any conditions specified in that authorisation.<sup>80</sup> An unclothed search cannot be authorised unless the person authorising the search believes, on reasonable grounds, that:

- the search is necessary
- the type and manner of the search are the least intrusive, proportionate to the circumstances, and necessary and reasonable to achieve the relevant search purpose.<sup>81</sup>

The Youth Justice Act now also requires a search that involves removing clothing or touching to be conducted by a search officer of the same gender as the young person.<sup>82</sup>

A 'body cavity search' is defined as a 'search of the rectum or vagina of the youth, but does not include a search of the youth by a scanning device that does not touch the youth'.<sup>83</sup> The amendments clarify that body cavity searches are not authorised under the Youth Justice Act in any circumstances.<sup>84</sup>

Force may be used if it is the only means by which the search can reasonably be conducted.<sup>85</sup> In such circumstances, the force must be the least amount of force that is reasonable and necessary to enable the search to be conducted.<sup>86</sup>

Under the Act, records of searches must be kept in a search register and made available for inspection by oversight bodies such as the Ombudsman and the Custodial Inspector.<sup>87</sup>

Following the 2022 amendments, the Youth Justice Act now better reflects domestic standards for strip searches.

The Inspection Standards for Youth Custodial Centres in Tasmania, issued in 2018 before the amendments to the Act, state that searches of a young person must be conducted safely, 'only when reasonable and necessary' and that they must be proportionate to the situation.<sup>88</sup> The Inspection Standards also state that unclothed searches should be a last resort, with pat searches, searches using metal detectors and increased surveillance used before an unclothed search. The Inspection Standards provide that staff should be appropriately trained to conduct searches and that the staff member conducting the search should be the same sex as the young person unless the young person identifies as transgender, in which case the young person should nominate the gender of the person they want to conduct the search.<sup>89</sup>

Under the Inspection Standards, unclothed searches are not to be routinely conducted on entry and exit to a detention facility where a young person has been in a secure vehicle while off the premises. The Standards confirm that cavity searches should never be conducted.<sup>90</sup>

Strip searches at Ashley Youth Detention Centre are also guided by internal policies and procedures set by the Secretary of the Department. The Centre's policies, in line with the Youth Justice Act, do not refer to the term 'strip search' but instead refer to an 'unclothed search'.<sup>91</sup> These policies and procedures give effect to obligations in the Youth Justice Act and reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in detail and make recommendations to strengthen them in Chapter 12.

## 4.2 Isolation

General Comment No. 24, issued by the United Nations Committee on the Rights of the Child, states that disciplinary measures such as 'placement in a dark cell, solitary confinement or any other punishment that may compromise the physical or mental health or wellbeing of the child' is a violation of Article 37 of the Convention on the Rights of the Child, and is strictly prohibited.<sup>92</sup> While not defined in the Convention, 'solitary confinement' is understood in international law to mean 'confinement of prisoners for 22 hours or more a day without meaningful human contact'.<sup>93</sup>

Specifically on isolation, General Comment No. 24 sets the following standards for solitary confinement and separation practices in youth detention, in the context of Article 37 of the Convention on the Rights of the Child:

Solitary confinement should not be used for a child. Any separation of the child from others should be for the shortest possible time and used only as a measure of last resort for the protection of the child or others. Where it is deemed necessary to hold a child separately, this should be done in the presence or under the close supervision of a suitably trained staff member, and the reasons and duration should be recorded.<sup>94</sup>

Similarly, the Havana Rules state:

Any disciplinary measures and procedures should maintain the interest of safety and an ordered community life and should be consistent with the upholding of the inherent dignity of the juvenile and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person.

All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited including ... placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.<sup>95</sup>

The link between solitary confinement or segregation practices and poor physical or mental health is recognised in several international instruments. Article 19 of the Convention on the Rights of the Child requires that signatories take steps to protect children from, among other things, 'mental violence' while in the care of a legal

guardian.<sup>96</sup> General Comment No. 13, issued by the United Nations Committee on the Rights of the Child, provides that, in this context, ‘mental violence’ can include ‘[p]lacement in solitary confinement, isolation or humiliating or degrading conditions of detention’.<sup>97</sup>

The 2015 Report of the Special Rapporteur on torture has stated that solitary confinement of any duration ‘constitutes cruel, inhuman or degrading treatment or punishment or even torture’.<sup>98</sup> The report recommended that solitary confinement of children in detention (of any duration and for any purpose) be prohibited.<sup>99</sup> The negative mental impact of solitary confinement was reiterated in the 2018 Report of the Special Rapporteur on the right to health.<sup>100</sup>

In Tasmania, section 133(1) of the Youth Justice Act defines isolation as ‘locking a detainee in a room separate from others and from the normal routine of the detention centre’. Section 133(2) of the Act states that a detention centre manager may only authorise isolation if a detainee’s behaviour poses an immediate threat to their own safety, that of another person or property and all other reasonable steps to prevent the harm or damage have been unsuccessful, or if it is in the interest of the security of the centre.<sup>101</sup>

Under the Act, reasonable force may be used, if necessary, to place a young person in isolation.<sup>102</sup> When in isolation, the young person must be ‘closely supervised and observed’ at intervals of no longer than 15 minutes.<sup>103</sup> The detention centre manager must also ensure the particulars of every use of isolation are recorded in an isolation register.<sup>104</sup> The period of isolation must not contravene any instructions issued by the Secretary of the Department.<sup>105</sup>

The Inspection Standards for Youth Custodial Centres in Tasmania provide that if it is necessary for a young person in detention to be placed into ‘separation, segregation or isolation’ for their own safety, the safety of others or for the good order of the detention centre, such actions should be:

- for the ‘minimum time necessary’
- only used when all other means of control have been exhausted
- recorded accurately in a separation and segregation register, including details of the young person’s routine while in isolation.<sup>106</sup>

In line with international obligations, the Inspection Standards suggest that staff closely supervise young people during isolation episodes.<sup>107</sup> The Inspection Standards also state that isolation should take place under conditions providing ‘not less amenity than normal accommodation’, except where a young person presents a serious risk of suicide or self-harm.<sup>108</sup>

The use of isolation at Ashley Youth Detention Centre is also guided by internal policies and procedures set by the Secretary of the Department. These policies and procedures are intended to give effect to the Youth Justice Act obligations and to reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in detail in Chapter 12.

### 4.3 Use of force

International law prohibits the use of restraint or force against young people in detention, except in exceptional circumstances. Both the 2019 General Comment No. 24 and the 2015 Report of the Special Rapporteur on torture state that restraint or force can only be used against a child in detention if that child poses an imminent threat of injury to themselves or others and only when all other means of control have been exhausted.<sup>109</sup> General Comment No. 24 also states that prison staff should be adequately trained in the use of force, and that force should never be used as a means of punishment:

Restraint should not be used to secure compliance and should never involve deliberate infliction of pain. It is never to be used as a means of punishment. The use of restraint or force, including physical, mechanical and medical or pharmacological restraints, should be under close, direct and continuous control of a medical and/or psychological professional. Staff of the facility should receive training on the applicable standards.<sup>110</sup>

General Comment No. 24 also provides that states should record, monitor and evaluate all incidents of restraint or force used on children in detention and that those who violate these rules should be punished.<sup>111</sup>

These principles are reflected in a range of other international instruments including the Havana Rules and the Nelson Mandela Rules.<sup>112</sup> These instruments describe best practice in relation to the use of force on detained young people as follows:

- The use of force is only permitted when it is strictly necessary—that is, where the child poses an imminent threat of self-harm or injury to others—and where other methods of control have been exhausted.<sup>113</sup>
- When the use of force is deemed strictly necessary, it must be used:
  - for the shortest possible time or a limited time<sup>114</sup>
  - without causing humiliation and degradation<sup>115</sup>
  - by properly trained staff<sup>116</sup>
  - only in self-defence, in response to attempted escape or in response to active or passive physical resistance.<sup>117</sup>

In Tasmania, section 132 of the Youth Justice Act prohibits the use of physical force against young people in detention unless the force is reasonable. The use of force must also be necessary to prevent the detainee harming themselves or anyone else, or damaging property, necessary for the security of the centre or otherwise authorised.

The Inspection Standards for Youth Custodial Centres in Tasmania provide that force must only be used ‘when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted’.<sup>118</sup> The Inspection Standards also state the following:

- The use of force must only occur for ‘the shortest time required’.<sup>119</sup>
- Force should never be used as punishment or to obtain a young person’s compliance.<sup>120</sup>
- Force should never be used in a way that causes humiliation or degradation.<sup>121</sup>
- All instances of the use of force should be recorded, investigated and reported.<sup>122</sup>
- Cameras should be used to record planned interventions involving the use of force.<sup>123</sup>
- A young person who has been subjected to a use of force should be provided health care following the incident.<sup>124</sup>

The Inspection Standards require that any use of force involve only approved techniques and restraints and that the young person should be given an opportunity to speak with staff not involved in the incident following the use of force.<sup>125</sup>

The use of force at Ashley Youth Detention Centre is also guided by internal policies and procedures set by the Secretary of the Department. These policies and procedures are intended to give effect to the Youth Justice Act obligations and to reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in Chapter 12.

## 4.4 Punishment, intimidation, humiliation, physical or emotional abuse, discrimination

As a party to the Convention against Torture, Australia is obligated to take effective legislative, administrative, judicial or other measures to prevent acts of torture.

The Convention against Torture defines torture as any act by which severe physical or mental pain or suffering is intentionally inflicted to punish, intimidate or coerce, or for any reason based on discrimination of any kind.<sup>126</sup> It occurs when inflicted by, or instigated with the consent or acquiescence of, a public official.<sup>127</sup>

Under the Havana Rules, all disciplinary measures constituting cruel, inhuman or degrading treatment are strictly prohibited, including corporal (physical) punishment or any other punishment that may compromise the physical or mental health of the juvenile concerned.<sup>128</sup>

In Tasmania, section 132 of the Youth Justice Act also prohibits corporal punishment that inflicts or is intended to inflict physical pain or discomfort as punishment; the use of any form of psychological pressure intended to ‘intimidate or humiliate’ the detainee; the use of any form of physical or emotional abuse; and the adoption of any kind of discriminatory treatment.

The Inspection Standards for Youth Custodial Centres in Tasmania state that no young person should experience disadvantage, discrimination or abuse while in custody.<sup>129</sup> Standard 8.6 covers behaviour management systems and states that rules must be applied fairly and consistently without discrimination. Standard 8.10 states that young people, staff and visitors understand that bullying and intimidating behaviour are not acceptable.<sup>130</sup>

## 5 Understanding the youth detention context in Tasmania

### 5.1 An overview of Ashley Youth Detention Centre

Ashley Youth Detention Centre is Tasmania’s primary dedicated youth detention facility.<sup>131</sup> After a refurbishment in 2022, Ashley Youth Detention Centre can accommodate up to 40 young people across five accommodation units at any given time.<sup>132</sup> The Centre is managed by the Department for Education, Children and Young People (formerly the Department of Communities) under the Youth Justice Act.<sup>133</sup> We outline the management, staffing and operations of Ashley Youth Detention Centre in Section 5.3.

The Centre is in regional Tasmania near the town of Deloraine, which has a population of about 6,000 people.<sup>134</sup> Deloraine is about 50 kilometres from Launceston and Devonport, and more than 200 kilometres from Hobart. During our Inquiry, we became aware that the geographical remoteness and isolation of the Centre may contribute to unfavourable outcomes for the young people detained there; for example, some young people cannot access the services required to support their complex needs. In many instances, family members, cultural support people, specialists (including medical practitioners, psychologists and alcohol and other drug support services) must travel from Hobart, Launceston or Melbourne to deliver services to young people at the Centre.<sup>135</sup>

An assessment of the Centre commissioned by the Tasmanian Government in 2016 concluded that the location of Ashley Youth Detention Centre ‘makes it difficult to deliver a throughcare approach, which builds on pro-social relationships with a young person’s family, community and service providers’.<sup>136</sup>

Ashley Youth Detention Centre operates on the site of the previous institution known as Ashley Home for Boys.<sup>137</sup> Ashley Home for Boys transitioned to a secure youth detention centre for males and females aged between 10 and 18 years on 28 June 2000.<sup>138</sup> Allegations of physical, sexual and emotional abuse made by former residents of Ashley Home for Boys have been the subject of a Tasmanian Ombudsman review, resulting in compensation and a State Government apology in 2005 to former wards of the state abused in care.<sup>139</sup> Some staff from Ashley Home for Boys continued to work at Ashley Youth Detention Centre once it opened and remained working there for many years.<sup>140</sup> Also, several current staff have been working in Ashley Youth Detention Centre since the early 2000s.<sup>141</sup> We discuss concerns about the culture and operations of Ashley Youth Detention Centre over the past two decades in Section 6 and throughout Volume 5.

## 5.2 Children and young people at Ashley Youth Detention Centre

### 5.2.1 Demographic profile

According to data published by the Australian Institute of Health and Welfare, on an average day in 2021–22 there were eight children and young people aged 10 to 17 years in detention in Tasmania and, of these, six were on remand.<sup>142</sup> The average length of time young people spent in detention during the year in Tasmania in 2021–22 was 72.5 days.<sup>143</sup> As with other jurisdictions, Tasmanian legislation requires that detention of children and young people should be a last resort and for the shortest time necessary.<sup>144</sup>

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, told us that children and young people are often detained on remand because they have nowhere else to live while their charges are being processed by the court.<sup>145</sup> Ms Phillips said that common factors associated with remanding rather than bailing children and young people include the lack of a fixed residence, the absence of family support (including kinship support) and appropriate supervision, the instability or breakdown of out of home care placements, and the presence of undiagnosed mental health issues or disability that has led to the offending behaviour.<sup>146</sup> Ms Phillips told us that many young people who have contact with the justice system ‘live on the street or couch surf’ due to limited stocks of immediately available housing or emergency accommodation for young people.<sup>147</sup> She noted ‘a magistrate or Justice of the Peace is rarely going to bail a young person without a stable address’.<sup>148</sup>



Vincenzo Caltabiano, former Director of Tasmania Legal Aid, told us this situation ‘leads to a greater number of the most vulnerable children being remanded in custody and exposes them to the adverse impacts of detention’.<sup>149</sup>

Mark Morrissey, former Commissioner for Children and Young People, observed that children and young people detained at Ashley Youth Detention Centre:

... often have serious psychological or emotional damage and issues, brain injury due to childhood trauma or conditions such as fetal alcohol spectrum disorder (FASD), family violence, chronic neglect, failed attachment and developmental delay.<sup>150</sup>

On an average day in youth detention in 2021–22, Aboriginal children and young people aged 10 to 17 years accounted for 44 per cent of the detention population in Tasmania for that age group, despite only comprising about 10 per cent of the total Tasmanian population aged 10 to 17 years.<sup>151</sup> The impacts of colonisation, including poverty and disadvantage, have continued to drive the over-representation of Aboriginal children in detention.

Although the Tasmanian Youth Custodial Information System does not capture information about young people with disabilities in detention, broader data suggests that adults and young people with mental and cognitive disabilities are over-represented in detention settings.<sup>152</sup> We heard that ‘significant mental health problems’ and previously unknown or unaddressed disability-related need are often not identified until children are in detention.<sup>153</sup> Ms Phillips questioned the adequacy of Tasmania’s mental health system, particularly the absence of a dedicated facility for young people experiencing mental health issues and complex behaviours.<sup>154</sup> Ms Phillips observed that ‘Ashley Youth Detention Centre is used to manage behaviour and address immediate risk rather than address[ing] the underlying issues’ that contribute to a young person’s offending.<sup>155</sup>

There are significant behaviour and learning challenges in the cohort of young people at Ashley Youth Detention Centre.<sup>156</sup> The Ashley School Principal, Samuel Baker, told us that the literacy and numeracy skills of students at the school are, in general, ‘many years behind their peers in the community’, predominantly due to socioeconomic disadvantage and having missed significant amounts of schooling.<sup>157</sup>

Data provided by the former Department of Communities indicates that 43 per cent of all young people in detention in Tasmania in 2020–21 had also been in out of home care.<sup>158</sup> Recent research indicates that, for young people with cognitive disability and complex support needs, the association between involvement in child protection and the justice system is particularly strong.<sup>159</sup>



## 5.2.2 Ashley Youth Detention Centre, reoffending and Risdon Prison

We heard that a high number of children cycle in and out of Ashley Youth Detention Centre in a relatively short period. Mr Caltabiano told us that more than 50 per cent of children aged between 10 and 16 years return to the Centre within 12 months of their release.<sup>160</sup> He observed that, ‘like detention and imprisonment for adults, detention for children tends to contribute to a cycle of recidivism and then institutionalisation’.<sup>161</sup>

Ms Phillips described a tendency for some young people in Tasmania to view Ashley Youth Detention Centre as a viable alternative to life outside. She told us that detention could provide a sense of belonging for the most disadvantaged young people in Tasmania, where ‘they do not have to worry about drug debts, a household where there is family violence, or how they are going to get food every day’.<sup>162</sup> Ms Phillips referenced one young person who asked for his bail to be revoked because ‘he wanted to go to school where he did not feel different’ and because ‘he did not feel he could avoid getting into trouble where he lived’.<sup>163</sup> Ms Phillips noted that, in the absence of structure, family support, routine and the services and infrastructure known to enhance social inclusion and personal opportunity, it is virtually impossible for some young people to imagine living in conventional and prosocial ways.<sup>164</sup>

We also heard about the correlation between children who are detained at Ashley Youth Detention Centre and their incarceration as adults at Risdon Prison.<sup>165</sup> Ms Phillips told us that she continues to represent many adult clients for whom she acted when they were children.<sup>166</sup> The frequency of this phenomenon has led Ms Phillips to refer to Ashley Youth Detention Centre as ‘the kindergarten for Risdon Prison’.<sup>167</sup> She told us that incarceration at Risdon Prison is ‘an expected course’ for some young people.<sup>168</sup>

Mr Morrissey similarly referred to the Centre as a ‘conduit’ for an adult criminal career. He highlighted the tendency for highly vulnerable young people to establish criminal networks in the Centre, which they maintained on release.<sup>169</sup> Professor Robert White, Emeritus Distinguished Professor of Criminology, University of Tasmania, described the incarceration of children and young people in detention centres and prisons as contrary to the rehabilitative and restorative ideals that are commonly associated with youth justice:

If you put somebody into, say, a youth prison, there is a whole bunch of things that accompany that, detachment from home, from school, a whole bunch of things, but also the stigma that’s attached to spending time inside, all [of] that then generates a track record which makes it more difficult for young people to succeed into the future and a similar process with the adult prisons, as well.<sup>170</sup>

## 5.3 Management, staffing and operations of Ashley Youth Detention Centre

In July 2018, the department responsible for Ashley Youth Detention Centre changed from the Department of Health and Human Services to the Department of Communities.<sup>171</sup> At this time, responsibility for administering the Centre sat with the Children and Youth Services division of the Department of Communities.<sup>172</sup> In October 2022, the Department of Communities was folded into the Department for Education, Children and Young People, which has overall responsibility for the health, safety and welfare of children and young people in detention at Ashley Youth Detention Centre.<sup>173</sup> As noted in the introduction to this volume, we use the term ‘Department’ in this volume to mean the department responsible at the relevant time for youth justice, with the specific department noted where required for clarity.

### 5.3.1 Management

The Secretary of the Department is responsible for the security and management of Ashley Youth Detention Centre and the safe custody and wellbeing of children and young people in detention.<sup>174</sup> From 2000, when the Centre was established, until October 2022, the Secretary delegated the power to issue instructions concerning the management of the Centre and the safe custody and wellbeing of children and young people in detention to the Deputy Secretary, Children, Youth and Families and the Director, Youth and Family Violence Services, although the Secretary still held ultimate responsibility.<sup>175</sup> Before October 2022, the Deputy Secretary reported directly to the Secretary of the Department and the Director reported to the Deputy Secretary, Children, Youth and Families.<sup>176</sup>

Before October 2022, the Director, Youth and Family Violence Services, also known by other titles including Director, Services to Young People and Director, Strategic Youth Services, was the senior executive in the organisational structure of Ashley Youth Detention Centre, but was not based at the Centre.<sup>177</sup> We have elected to refer to this role as Director, Strategic Youth Services. Previously, this position oversaw other areas in the family violence and youth justice portfolio, but, in early 2022, oversight of Ashley Youth Detention Centre became a dedicated role.<sup>178</sup> In August 2022, the newly created position of Executive Director, Services for Youth Justice became responsible for Ashley Youth Detention Centre. This position reports to the Associate Secretary of the Department for Education, Children and Young People.<sup>179</sup>

Before the October 2022 restructure, the Manager, Custodial Youth Justice (‘Centre Manager’) reported to the Director, Youth and Family Violence Services.<sup>180</sup> The Centre Manager was responsible for managing the day-to-day operations of the Centre, developing and leading a management team, and providing direction for programs at the

Centre.<sup>181</sup> As of May 2022, there were four direct reports under the Centre Manager—an Assistant Manager for Operations; a Manager, Professional Services and Policy; a Fire, Safety and Security Coordinator; and a Practice Manager.<sup>182</sup>

The general hierarchy has been in place at Ashley Youth Detention Centre since at least 2007, with some changes over time to specific reporting lines and roles. This hierarchy has the Secretary of the Department ultimately responsible for Ashley Youth Detention Centre, the Director level and above located in the Department, a Centre Manager at the Centre, and two streams (Operations and Professional Services) in the Centre.<sup>183</sup>

### 5.3.2 Staffing and operational structure

In this section, we outline the operational structure of Ashley Youth Detention Centre in broad terms, noting that the structure has changed over time. As noted, since at least 2007, the Centre’s organisational structure has been primarily divided between Operations and Professional Services staff, with each cohort reporting to the Centre Manager.<sup>184</sup>

Ashley Youth Detention Centre’s Operations Team works in the residential units and provides the day-to-day supervision, support and care of young people.<sup>185</sup>

The Operations Team includes:

- the Operations Manager, who manages the day-to-day operations of Ashley Youth Detention Centre and leads the Operations Team
- Operations Coordinators, who oversee the delivery of services to young people and coordinate and supervise youth workers
- youth workers, who assist in the daily operation of residential units and supervise and support young people attending programs and activities or taking part in daily routines.<sup>186</sup>

We understand that Operations staff work in fixed teams with an Operations Coordinator and multiple youth workers per team, and that teams are established with staff skills, gender and experience in mind.<sup>187</sup>

Stuart Watson, Manager, Custodial Youth Justice (‘Centre Manager’), told us that the Operations Team, specifically the youth workers:

... represent a parent-like person who assists the young people to meet their daily goals, including making their beds, cleaning, laundry, pro-social conversation and recreational activities such as playing cards or kicking the football.<sup>188</sup>

Operations staff also supervise offsite excursions and may engage in behaviour management actions such as restraining a young person where required.<sup>189</sup>

The Professional Services and Policy team was a multidisciplinary team that supported the development, review and implementation of relevant policies, procedures and programs.<sup>190</sup> The team also provided case management and therapeutic supports to young people.<sup>191</sup> It led the development of case or care plans and exit plans, undertook case conferencing and managed referrals to other services in the community.<sup>192</sup> It also advised, developed and delivered training to the Operations Team, including on behaviour management strategies.<sup>193</sup> Today, the team is known as ‘Ashley Team Support’ and it conducts similar functions. For the purposes of our report, we refer to it as the ‘Professional Services Team’.

The Professional Services Team includes:

- the Manager, Professional Services and Policy, who leads the development, review and implementation of practice standards, policies, procedures, programs and case management strategies, and manages and supervises some, but not all, Professional Services staff
- the Policy and Program Support Officer, who oversees programs and services to young people and provides policy advice on restorative justice and therapeutic responses
- the Practice Manager, who leads, supervises and mentors Operations staff and the Training Coordinator, and leads the development and evaluation of learning and development programs at the Centre
- the Training Coordinator, who develops, implements and evaluates staff training and professional development
- the Program Coordinator, who coordinates and facilitates program delivery, in conjunction with Ashley School
- the Case Management Coordinator, who maintains the case management system at Ashley Youth Detention Centre and provides direction, support and supervision to staff involved in case management
- the Case Management Officer, who assists with the provision of case management services.<sup>194</sup>

We have not received an updated organisational structure for the internal Ashley Youth Detention Centre management since the October 2022 restructure, although we have noted the creation of new positions in our discussion of the Keeping Kids Safe Plan in Chapter 12.

The conduct of staff at Ashley Youth Detention Centre is governed by standard operating procedures, which cover topics as diverse as the supervision and movement of young people, admissions, isolation, use of handcuffs, health care and searches of children and young people.<sup>195</sup>

Other Tasmanian government departments provide healthcare and education services to the children and young people detained at Ashley Youth Detention Centre.

### 5.3.3 Healthcare services

Correctional Primary Health Services and Ashley Youth Detention Centre work together to assess the physical and mental health status of young people in custody; deliver appropriate health services for young people; offer timely responses and treatment; and provide appropriate referrals and access for specialised assessment and treatment.<sup>196</sup> They also share responsibilities for the care of young people with physical and cognitive disabilities.<sup>197</sup>

Michael Pervan, former Secretary of the Department of Communities, told us that the Department of Health, which was ‘independent’ of the former Department of Communities’ organisational structure, was responsible for staffing, supporting and running the general health service provided to young people at Ashley Youth Detention Centre.<sup>198</sup>

Correctional Primary Health Services has overseen Ashley Youth Detention Centre’s Health Team since 2011.<sup>199</sup> Correctional Primary Health Services sits in the Department of Health, under the umbrella of Statewide Mental Health Services.<sup>200</sup> In conjunction with its role at the Centre, Correctional Primary Health Services provides services to Risdon Prison, Hobart Reception Prison and Launceston Reception Prison.<sup>201</sup> Correctional Primary Health Services is under the management of the Group Director of Forensic Mental Health and Correctional Primary Health Services (‘Group Director’).<sup>202</sup>

Health practitioners at the Centre are employees of (or are otherwise engaged by) the Department of Health.<sup>203</sup> Members of the Centre’s Health Team do not report to Ashley Youth Detention Centre management or the Department for Education, Children and Young People, but to officials in the Department of Health.<sup>204</sup> Health Team members are also subject to relevant Department of Health legislation, policies and procedures.<sup>205</sup>

This organisational separation is reflected in a memorandum of understanding between the former Department of Communities and Correctional Primary Health Services, dated May 2021, which is in place until February 2026.<sup>206</sup> The Group Director told us that a memorandum of understanding in some form has been in place since 2011, when health services at Ashley Youth Detention Centre were transferred to Correctional Primary Health Services.<sup>207</sup>

We understand that the memorandum of understanding is reviewed annually. It states that the role of Correctional Primary Health Services at Ashley Youth Detention Centre is to provide:

- primary health and mental health care and treatment
- specialist referrals
- specialist mental health care and treatment
- initial treatment for Centre staff who are injured at work.<sup>208</sup>

The specific services to be provided by Correctional Primary Health Services are outlined in a schedule to the memorandum of understanding.<sup>209</sup>

While the Department of Health plays a central role in delivering healthcare services at Ashley Youth Detention Centre, Secretary Pervan confirmed that the former Department of Communities retained the ‘overall responsibility’ for the health, safety and welfare of young people at the Centre.<sup>210</sup> This is reflected in the memorandum of understanding.<sup>211</sup>

Importantly, the memorandum of understanding sets out that Ashley Youth Detention Centre is responsible for:

- providing timely referrals to clinicians for health assessments according to existing policies
- facilitating transports and escorts to enable residents to attend appointments with health service providers in the Centre and externally
- providing Correctional Primary Health Services with information that will facilitate the ongoing health management and care of residents.<sup>212</sup>

The Health Team at Ashley Youth Detention Centre is made up of nursing staff, medical officers (doctors) and mental health professionals. Nursing staff appear to provide the bulk of healthcare services at the Centre. The Nurse Unit Manager is responsible for health services operations and is employed for 0.5 full-time-equivalent hours (working a further 0.5 full-time-equivalent hours at Launceston Reception Prison).<sup>213</sup> The Nurse Unit Manager is on site at Ashley Youth Detention Centre most days and provides on-call assistance and shift cover as required.<sup>214</sup> Any on-call assistance provided by the Nurse Unit Manager is unpaid.<sup>215</sup>

The Nurse Unit Manager oversees registered nurses who provide services on site.<sup>216</sup> There is one registered nurse at the Centre for 12 hours a day, seven days a week, between the hours of 7.00 am and 7.00 pm (in addition to the Nurse Unit Manager).<sup>217</sup> Outside those hours, a nurse is available on call.<sup>218</sup>

Nursing staff at Ashley Youth Detention Centre report to the Department of Health. The Nurse Unit Manager and registered nurses report to the Assistant Director of Nursing at the Department of Health, who reports to the Director of Nursing for Forensic Health Services ('Director of Nursing'), who in turn reports to the Group Director.<sup>219</sup>

The Nurse Unit Manager and registered nurse on shift are stationed in an area known as the 'health corridor' or 'health centre' at Ashley Youth Detention Centre.<sup>220</sup> In that area, there are two offices, a consultation room, a treatment room and a secure pharmaceutical storage area, with a medicine administration hatch.<sup>221</sup> Most treatments and consultations take place in the health centre, but treatment can be provided elsewhere at the Centre if required—for example, in the gym or in the young person's unit.<sup>222</sup>

A medical officer is employed at 0.2 full-time-equivalent hours at Ashley Youth Detention Centre and is supported by on-call medical officers for after-hours attendances.<sup>223</sup> The medical officer provides consultative assistance to nursing staff, including by prescribing medication. As with other health staff at Ashley Youth Detention Centre, medical officers are employees of the Department of Health and report to the Clinical Director, Correctional Primary Health Services.<sup>224</sup> The Nurse Unit Manager told us that medical officers are only on site at Ashley Youth Detention Centre for two hours a week.<sup>225</sup>

Regarding mental health support, a 'forensic' or 'clinical' psychologist is usually employed by the Department of Health for 1.0 full-time-equivalent hours.<sup>226</sup> The psychologist reports to the Manager, Community Forensic Mental Health Services.<sup>227</sup> We understand the role of the psychologist to be:

- addressing young people's criminogenic needs and providing therapy
- undertaking self-harm and suicide risk assessments
- educating young people on 'pro-social attitudes and behaviour modification'.<sup>228</sup>

The psychologist position has been vacant since November 2021.<sup>229</sup> The Group Director told us that psychology telehealth sessions were available to detainees between November 2021 and June 2022.<sup>230</sup> He also said that 'alternative services have been access[ed] from private providers and there is a clinic 3 hours per week via telehealth'.<sup>231</sup> The Group Director also told us that, given the ongoing challenges in recruiting a psychologist, Correctional Primary Health Services decided in March 2022 to change the psychology input into a sessional timetable rather than a psychologist being permanently based at the Centre.<sup>232</sup>

A child psychiatrist also provides onsite care to young people at Ashley Youth Detention Centre.<sup>233</sup> The psychiatrist visits the Centre one day a month to assess, diagnose and treat young people.<sup>234</sup> This psychiatrist is not an employee of the Department



of Health and is instead funded via a Commonwealth Government outreach program.<sup>235</sup> The Department of Health provides clinical oversight of the psychiatrist.<sup>236</sup> Otherwise, psychiatry services for children and young people in detention are accessed via telehealth.<sup>237</sup>

All Ashley Youth Detention Centre Health Team members must be registered with the Registration to Work with Vulnerable People Scheme, and those employed by the State must comply with the State Service Code of Conduct.<sup>238</sup> We understand that there is no specific training for health staff who work in youth detention, aside from the normal tertiary education required for medical roles.<sup>239</sup> Some nursing staff may undertake further education relevant to youth detention as part of their continuous professional development, such as for trauma-informed care and drug and alcohol dependency.<sup>240</sup> However, this does not appear to be specific to the youth detention context. Health services for children in detention are discussed in Chapter 12.

### 5.3.4 Education services

The right of children and young people to access education continues in detention. A core principle of delivering youth justice services under the Youth Justice Act is that ‘no unnecessary interruption of a youth’s education’ occurs so far as the circumstances of the individual case allow.<sup>241</sup>

Ashley School, which is a Tasmanian Government school on the Ashley Youth Detention Centre site, delivers schooling to children and young people in detention. Young people do not start attending Ashley School until they have completed a school induction delivered by an Ashley School teacher or the principal, which occurs after they are remanded or detained for seven days.<sup>242</sup> Students are generally expected to attend school from 9.00 am to 2.30 pm every weekday.<sup>243</sup> Attendance at Ashley School is consistent with the attendance policy at other Tasmanian Government schools: there is an expectation that young people attend school if they can.<sup>244</sup> A student might not attend a school program at Ashley Youth Detention Centre for a variety of reasons including due to a safety risk assessment, the need to attend an offsite appointment or because a student has indicated that they ‘don’t want to attend’.<sup>245</sup>

Ashley School offers a curriculum in literacy and numeracy, as well as specialist and vocational classes including art, woodwork, cooking, STEM (science, technology, engineering and mathematics), physical education, health, ‘fit gym’ and Aboriginal studies.<sup>246</sup> The ‘core’ curriculum in literacy and numeracy forms about 30 per cent of each student’s schooling and is tailored to meet each student’s individual learning needs.<sup>247</sup> Ashley School also promotes and educates young people in prosocial behaviours and values.<sup>248</sup>



Mr Baker told us that most, if not all, Ashley School students display challenging school behaviours and that Ashley School staff are often required to be hypervigilant, flexible, adaptable and resilient.<sup>249</sup>

We heard that Ashley School staff apply a therapeutic educational model that incorporates positive behaviour support to promote and acknowledge the behaviour they want to see in young people.<sup>250</sup> Ashley School also provides a highly scheduled timetable and explicit expectations and learning intentions, so students know what is required and how to achieve it, and to minimise surprises or overstimulation.<sup>251</sup>

Mr Baker told us that Ashley School staff use a variety of strategies to support students to increase their functional literacy and numeracy including individual learning plans, individualised learning tasks, collaborative planning, high-intensity teaching strategies and high teacher-to-student ratios.<sup>252</sup> He said that, for most classes, at least one teacher and one teacher assistant are assigned to no more than four students.<sup>253</sup>

Until October 2022, the Department of Education managed Ashley School independently from the former Department of Communities.<sup>254</sup> The Department of Education was responsible for staff appointments for, support to, and the day-to-day running of, Ashley School.<sup>255</sup> Mr Baker told us that the Department of Communities and the Department of Health shared essential information and feedback about the young people at Ashley Youth Detention Centre with the Department of Education to support Ashley School in making decisions in the interests of detained young people.<sup>256</sup>

Since October 2022, the newly formed Department for Education, Children and Young People has been responsible for administering Ashley School. As of August 2022, Ashley School was staffed with 6.0 full-time-equivalent teachers, 1.28 full-time-equivalent teacher assistants, 0.52 full-time-equivalent education facility attendants and a full-time School Business Manager.<sup>257</sup> Ashley School staff have to follow the processes, policies and strategic planning of the Department for Education, Children and Young People.<sup>258</sup> Education services for children in detention are discussed in Chapter 12.

### **5.3.5 Decision making and recommendation forums**

Secretary Pervan told us that Ashley Youth Detention Centre ‘operates as a multidisciplinary centre’ and that the Operations and Professional Services Teams ‘work collaboratively through multidisciplinary teams, weekly review meetings, and program meetings’.<sup>259</sup> The structure of team meetings changed in mid-2022. In this section, we set out the relevant features of teams and meetings before this change.

The Centre Support Team was a longstanding feature of Ashley Youth Detention Centre’s operation until mid-2022. The Centre Support Team determined a young person’s ‘colour level’ in line with the Behaviour Development System (replaced with the Behaviour Development Program in April 2022).<sup>260</sup> The Behaviour Development System and the Behaviour Development Program are discussed in Section 5.4 and Chapter 11,

Case study 3, but essentially the System/Program is a behaviour management tool used to incentivise engagement and positive behaviour from young people. It allocates privileges or restrictions to a child or young person based on their ranking in a colour system. A child or young person's colour corresponds to their behaviour and is reviewed at least weekly.

The Centre Support Team also determined a child or young person's eligibility for leave, decided which unit a child or young person should be placed in, reviewed and managed responses to incidents in the Centre, and managed formal requests from children and young people, including for offsite activities and unit changes.<sup>261</sup>

The Centre Support Team's membership changed over time and, although staff from the Professional Services Team were included as general members, it primarily included staff from the Operations Team and was chaired by the Operations Manager.<sup>262</sup>

The Centre Support Team met weekly and held interim meetings as required (either by the Centre Manager or Chair, or if requested by a general member and with the chairperson's or Centre Manager's approval).<sup>263</sup> The outcomes of these meetings, including a child or young person's colour rating and unit placement, were communicated to detainees after the weekly meeting. Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, described this process in the following terms:

The [Centre Support Team] would meet from 9am to 12pm every Monday, and the Centre would then be locked down from approximately 12pm to 2pm and every child sent to their cell in what was effectively entirely accepted isolation. The [Centre Support Team] members, as a group, would go to each room and speak to each child about the outcome of the [Centre Support Team] meeting for them; whether they had moved up or down in the colour behaviour management system, and why. The children would be forced to sit on their beds while the adults stood to deliver the results. It would often not be good news and children would become distressed.

There would be four to five adults in the room, speaking to the child about how naughty and bad they had been. It was a visibly crushing and humiliating experience for a child. I could see how dehumanising and traumatising it was to have people they were generally afraid of, standing over them and telling them they were essentially bad. There was always a particularly negative lean on the feedback provided to each child and after difficult news was delivered the child would be locked into their cell alone whilst we went to see the other children.<sup>264</sup>

Alysha also told us she considered the way in which the Centre Support Team delivered its decision to children to be 'inappropriate, re-traumatising and ineffective'.<sup>265</sup>

We have been advised that this practice has since changed and is now referred to as the Weekly Review Meeting.<sup>266</sup> Following this Weekly Review Meeting, in the early afternoon the Operations Coordinator visits the units.<sup>267</sup> The Operations Coordinator

and unit staff let the children and young people know their ‘colour’ and give them their incentives award/voucher if applicable through an incentives-based process.<sup>268</sup> We were advised that the units have ‘quiet time’ from 12.30 pm until 1.15 pm, which immediately follows lunch.<sup>269</sup> In the following couple of days (Tuesday/Wednesday depending on the number of detainees), the Ashley Team Support staff (Case Management) and an Australian Childhood Foundation staff member visit the young people to discuss their therapeutic plan, the reason for the Weekly Review Meeting decision, and their future needs. This is done in a meeting room, not on the unit, to give the young people the space and privacy to discuss any issues or concerns they might have.<sup>270</sup>

The Multi-Disciplinary Team has also existed for a long time at Ashley Youth Detention Centre. Copies of Multi-Disciplinary Team terms of reference documents made available to us indicate that the purpose, membership and decision-making protocols of the team have not changed substantially since at least 2018.<sup>271</sup> We are aware of Multi-Disciplinary Team meetings as early as 2012.<sup>272</sup>

The Multi-Disciplinary Team provides ‘assessment, review, monitoring and a referral forum to address the needs of all young people’ at Ashley Youth Detention Centre.<sup>273</sup> Its purpose is to ‘optimise health outcomes, address other risk factors and plan for the young person’s return to the community’.<sup>274</sup>

Among the tasks and responsibilities of the Multi-Disciplinary Team are:

- discussing care and case management plans for all young people at Ashley Youth Detention Centre
- developing plans to address risk factors and to provide ongoing reviews of those plans
- providing ‘professional liaison and support’ for Operations staff ‘in the supervision and management of young people as requested and/or required’.<sup>275</sup>

Case plans, safety plans and exit plans are updated following Multi-Disciplinary Team discussions.<sup>276</sup>

We understand the membership of the Multi-Disciplinary Team has changed over time but has generally reflected a broad range of Professional Services staff and a small representation from the Operations Team.<sup>277</sup> The chairperson is the Manager, Professional Services (or delegate, Care Management Coordinator).<sup>278</sup> Other staff or stakeholders (such as a youth worker or program provider) may be invited to a Multi-Disciplinary Team meeting as required.<sup>279</sup> Mr Watson, Centre Manager, told us that regular invitees include nurses, paediatricians, psychologists, psychiatrists and representatives of the National Disability Insurance Scheme.<sup>280</sup>

According to its terms of reference, the Multi-Disciplinary Team develops, implements and documents responses to individual care/case management plans and provides feedback through the case management process to the child or young person in detention.<sup>281</sup>

In mid-2022, a Risk Assessment Process Team was established. Pamela Honan, Director, Strategic Youth Services in the Department, told us that this team was established in response to concerns that Ashley Youth Detention Centre staff felt unsafe at work because of the behaviour of children and young people in detention, the behaviour of staff and/or unsafe staffing levels.<sup>282</sup> The Risk Assessment Process Team's terms of reference are effective from 8 June 2022.<sup>283</sup> Membership of the team includes the Ashley Team Support or Operations Manager as the Chair, the Assistant Manager of the Centre, Case Management Coordinator, Practice Manager, Operations Coordinator and representatives from Education (School Principal), the Department of Health (Clinical Psychologist/CPHS nurse) and a guest at the discretion of the Chair.<sup>284</sup> The terms of reference note that the team reports to the Senior Management Team, which reports to the Director, Youth and Family Violence Services.<sup>285</sup>

The Risk Assessment Process Team's terms of reference provide that the team's purpose is to 'establish a reliable, evidence-based framework for decision-making, analysis, planning, and implementation of risk management strategies to support staff with the ongoing care of young people' at Ashley Youth Detention Centre.<sup>286</sup>

The Risk Assessment Process Team is primarily involved in reviewing incidents. Its tasks and responsibilities are described in the terms of reference as, among other things:

- analysing incidents, including considering underlying causes and assessing all available evidence (including closed-circuit television)
- developing behavioural management plans for young people involved in a 'significant incident'
- making recommendations to the Centre Manager
- providing advice on operational practices and procedures
- providing practical support and advice for managing risks.<sup>287</sup>

The terms of reference state that meetings are held 'as per the category timeframes for responding to a significant incident and following a new admission'.<sup>288</sup> Two categories of incidents should initiate a response from the Risk Assessment Process Team:

- Category one incidents are incidents that are ‘significantly serious and critical in nature’.<sup>289</sup> These are defined to include ‘all incidents involving immediate and/or ongoing acute risk’.<sup>290</sup> Examples include attempted suicide or significant self-harm, actual or alleged sexual assault, uses of force or physical assaults requiring medical treatment, ‘pattern[s] of behaviour ... that on a cumulative basis are a serious concern to safety’ and riotous behaviour.<sup>291</sup>
- Category two incidents are incidents that are ‘significantly serious but involve a less critical and/or immediate level of risk to the safety and wellbeing of young people, staff, and the Centre’.<sup>292</sup> Examples include other physical assaults, attempted assaults, ‘sexualised behaviours’ (such as sexual threats, sexually demeaning language or indecent exposure) and having contraband.<sup>293</sup>

Category one incidents require a response from the Risk Assessment Process Team within two hours if possible, and no more than 24 hours.<sup>294</sup> Category two incidents require a response from the team on the same or next business day.<sup>295</sup>

All other incidents are considered in the Weekly Review Meeting.<sup>296</sup> The terms of reference for the Weekly Review Meeting state that it contributes to ‘celebrating the successes of young people and assists in the development of behaviour support strategies’.<sup>297</sup> They state that, as part of the program to engage with young people and incentivise positive behaviour, the Weekly Review Meeting will review information and reports on young people to determine their colour level.<sup>298</sup> Membership of the Weekly Review Meetings is the Operations Manager (Chair), the on-duty Operations Coordinator, Case Management Coordinator, a youth worker representative from respective residential units, Clinical Practice Consultant and support officer (alternate Chair), clinical psychologist and School Principal, and an administrative officer as executive support.<sup>299</sup>

Since introducing the Risk Assessment Process Team, the Weekly Review Meeting is no longer responsible for risk assessment or managing serious incidents.<sup>300</sup>

When required, the Risk Assessment Process Team also determines a young person’s unit allocation, although we understand this remains the usual responsibility of the Weekly Review Meeting.<sup>301</sup> Unit placement decisions are discussed in Section 5.5.

We are also aware that there is a Program Assessment Team meeting to assess the suitability of placing detainees in programs offered by the Centre, including off site.<sup>302</sup> Membership of the Program Assessment Team is the Program Coordinator, the Case Management Coordinator, the Operations Manager, the Operations Coordinator and the Ashley School Principal.<sup>303</sup>

## 5.4 Behaviour Development System

A program for behaviour development was implemented at Ashley Youth Detention Centre in 2001.<sup>304</sup> Historically, it was known as the Behaviour Development System.<sup>305</sup> In April 2022, it was replaced with the Behaviour Development Program.

As mentioned, the Behaviour Development System was established as a behaviour management tool under which children and young people in detention were allocated a colour rating based on their behaviour, which would, in turn, determine the privileges or restrictions for which they were eligible. The new Behaviour Development Program similarly operates as a behaviour management tool.

The case studies in Chapter 11 deal with incidents before April 2022. Therefore, we have summarised in this section the Behaviour Development System in place before that time. We consider the Behaviour Development Program and its appropriateness in Chapter 12.

The former Behaviour Development System had two distinct schemes: the ‘Incentive Scheme’ and the ‘Incident Management Scheme’.<sup>306</sup> Together, the stated aims of these schemes were to:

Support the positive behaviour and manage the negative behaviour of young people in custody.

Encourage young people in custody to understand the consequences, both positive and negative, of their choices.

Integrate the key principles of restorative justice into the direct management of young people in custody (i.e. responsibility, reparation, diversion, rehabilitation and deterrence).

Provide a simple, clear and fair system that can respond consistently, accurately and in a timely manner to the behaviour of young people in custody.<sup>307</sup>

The following discussion focuses on the Incentive Scheme.

### 5.4.1 Colour system

Detainees were allocated one of four (or five) colour levels under the Behaviour Development System, corresponding to the perceived level of risk demonstrated by a child or young person at the time. Those colours were (from highest to lowest risk):

- Red—The red level was applied to young people who posed ‘an immediate threat’ to Centre security and safety, including to staff and young people.<sup>308</sup> Examples of such immediate threats included escape, attempted escape, assaultive behaviour, possession of a weapon or a ‘persistent history’ of contraband possession and/or use.<sup>309</sup> Young people who incited others to ‘behave in a way that is subversive and/or disruptive’ may also have been placed on the red level.<sup>310</sup>

- Orange—The orange level ‘represent[ed] a transition from red ... to a more settled and acceptable behaviour’.<sup>311</sup> It was applied to young people who demonstrated ‘medium level risks behaviours’, including ‘an accumulation of low-level incidents and/or an uncooperative or disinterested attitude’.<sup>312</sup>
- Yellow—The yellow level applied to young people who were ‘starting to show a higher level of pro-social responsibility and acceptance, participation in programs was on the increase and young people were attempting to meet their goals’.<sup>313</sup> It was applied to all new admissions.<sup>314</sup>
- Green—The green level was applied to young people ‘promoting a high level of pro-social behaviour, tak[ing] responsibility for their actions and participating fully in Case Management Case Plan Review’.<sup>315</sup>

A fifth colour, blue, was a feature of the Behaviour Development System at various times (at least in practice).<sup>316</sup> It was applied to the highest risk detainees and severely restricted their freedoms. The blue colour level, also known as ‘the Blue Program’, was most recently used at Ashley Youth Detention Centre for a period in 2019, although we note that Secretary Pervan gave evidence suggesting that versions of the Behaviour Management System that included the Blue Program were not ‘formalised or approved’.<sup>317</sup> The Blue Program is discussed in Chapter 11, Case study 3.

Young people could also earn daily ‘points’ based on their behaviours, which would contribute to their colour level.<sup>318</sup> We understand the criteria for these points were set out in a Daily Incentive Assessment sheet.<sup>319</sup>

Factors such as a young person’s attendance at programs or school, the level of responsibility they displayed in addressing their behaviour and the number of incidents they had been involved in would also contribute to their colour level.<sup>320</sup>

The Centre Support Team determined a young person’s colour level weekly or at interim meetings as required.<sup>321</sup> Decisions at interim meetings were required to be ratified at the next standing meeting of the Centre Support Team.<sup>322</sup>

#### 5.4.2 Benefits and restrictions

Each colour level was allocated particular ‘benefits’ or ‘restrictions’.<sup>323</sup>

Some of these benefits and restrictions appeared to correspond to the level of risk a young person was perceived to pose and the need to control their activities in the interests of safety or security, noting that the perceived risks may not have been imminent. For example, a young person on the green level was eligible for all activities and programs at the Centre, while a young person on the red level was only eligible for activities and programs in their unit.<sup>324</sup>



Other restrictions appeared more punitive (with no apparent risk management or harm prevention aim). For example, a young person on the red level had a bedtime of 7.30 pm, compared with a bedtime of 10.00 pm for a young person on the green level, though we note that the bedtime on green level appears to have been amended to 9.00 pm in September 2022 according to revised Unit Rules.<sup>325</sup> Other benefits and restrictions related to canteen allowances, eligibility for leave, access to visitors and the number of phone calls, among other things.<sup>326</sup>

In addition to their colour designation, children and young people could also earn points to use on incentives.<sup>327</sup> Incentives included more television time, extra phone calls, later bedtimes and access to a DVD player or gaming device.<sup>328</sup>

## 5.5 Placement decisions

Young people at Ashley Youth Detention Centre live in one of four units, in which they are assigned their own bedroom. When a unit is in use, one or more young people may be housed in the unit at any one time. Decisions are made regularly about which unit a young person stays in.

We understand that before 31 May 2022, the Centre Support Team determined unit placements (during standing weekly meetings or as part of interim meetings).<sup>329</sup> Most evidence we received stated that placements were reviewed at least weekly.<sup>330</sup> One staff member said that placement decisions were reviewed every day and that decisions were talked about ‘regularly’ by staff.<sup>331</sup> Another staff member said that placement decisions were regularly reviewed by the Centre Support Team ‘anything from [every] one or two days to [once] a week’.<sup>332</sup>

We received evidence that placement decisions took into account some or all of the following factors: age, gender, safety/security, legal status, length of sentence, individual needs, behavioural issues, relationship dynamics between young people and staff, and the views of staff.<sup>333</sup>

Patrick Ryan, former Manager, Custodial Youth Justice (‘Centre Manager’), told us that the relevant procedure ‘allowed for operational dynamic decisions to be made by the Operations Coordinator’.<sup>334</sup> Piers (a pseudonym), who held various positions at the Centre including operational, policy and managerial roles, told us that decisions made for a ‘safety and security reason’ were the responsibility of the Operations Manager and Operations Coordinator.<sup>335</sup> We understood Mr Ryan’s and Piers’ comments to mean that Operations staff could initiate a unit move in emergency circumstances, such as during a riot. At least one policy dating back to 2017 acknowledged that the Operations Coordinator could ‘advise the Operations Manager/On Call Manager if a young person/s is required to be moved for operational reasons from a unit’.<sup>336</sup> That policy did not define what constituted a suitable ‘operational reason’.



We received evidence that unit placement decisions made after hours due to new admissions or behavioural issues were made by the On Call Manager and the Operations Coordinator.<sup>337</sup>

Policy documents dating back to 2017 indicated that young people could make a formal request for a unit transfer, which the Centre Support Team would consider.<sup>338</sup>

Some Ashley Youth Detention Centre staff noted that unit placement decisions often required a fine balance between operational realities and the individual needs of young people. Those operational realities often included staffing issues. For example, a former Manager, Professional Services and Policy, reflected:

Over my time, thousands of placement decisions were made but until pressure came on in 2015 to reduce staffing levels and hence close down Units for a period, the prime motivation for Unit placement was what was in the best interests of the young person on the available known factors and information.

It goes without saying that deciding what was in the best interests of the child was often choosing the best out of a poor range of options.<sup>339</sup>

We discuss placement decisions since May 2022 in Chapter 12.

## 5.6 Incident reporting

During our Inquiry, we heard of several incidents at Ashley Youth Detention Centre, including riots and harmful sexual behaviours between young people. When an event occurs that staff cannot contain or readily resolve—for example, a potentially violent situation—and this requires immediate assistance in dealing with one or more young people, staff can initiate a ‘code black’.<sup>340</sup> This means that the Operations Coordinator or designated youth worker and any other available staff member trained in non-violent crisis intervention who can safely leave their post must go to the location, evaluate the scene and coordinate a response.<sup>341</sup>

Staff must also record and report an incident that has arisen from the behaviour of a young person or young people. Incident reporting at Ashley Youth Detention Centre is governed by the *AYDC Incident Reporting Procedure* and the *AYDC Incident Reporting form*.<sup>342</sup> Staff need to record details of the incident, including the date, time and location of the incident, the names of those involved or otherwise present (including staff), a description of the incident and a description of any evidence gathered.<sup>343</sup>

Staff also need to identify any ‘personal factors’ that may be affecting the young person.<sup>344</sup> These include, for example, age/maturity, cognitive development, emotional regulation, fear, lack of family contact, physical development, sexuality/gender, substance withdrawal and whether the young person has an impending court date.<sup>345</sup>

‘Moderating factors’ must also be identified—for example, the extent to which a young person was incited or provoked by another, whether the young person accepted responsibility for their actions and whether the young person cooperated with staff.<sup>346</sup>

For each young person involved, the staff member must also note whether the young person was searched or if practices such as force, mechanical restraints or isolation were used against the young person, and identify the nature of the young person’s involvement in the incident (such as being a witness or participant).<sup>347</sup>

The staff member must support each young person involved to prepare a witness or victim statement and then collect their completed statement.<sup>348</sup>

Staff must categorise the incident into one of three categories:

- Recorded incident—an incident of a ‘very minor nature, where there is insufficient evidence to support a Minor Incident or a Detention Offence’.<sup>349</sup>
- Minor incident—a breach of Centre rules that ‘does not warrant court action or substantiation of evidence at the level required by a court’.<sup>350</sup> Examples include disobeying published rules and reasonable instructions; lying; abusive, indecent, threatening language; behaviour ‘of a low-level nature’; petty stealing; ‘[d]eliberate harassment or provocation’ of staff, visitors or young people of a low level; play fighting; and minor damage to government property.<sup>351</sup>
- Detention offence—detention offences are prescribed by the Youth Justice Act.<sup>352</sup> These include, for example, absence from a detention centre without lawful authority; assault of another person; possession of a weapon; wilful damage or destruction of property; using threatening language or a threatening manner; behaving in a disorderly or riotous manner; and possession or use of unauthorised substances.<sup>353</sup>

The staff member may gather evidence to support the incident report. The report is reviewed by the Operations Coordinator, who must oversee the quality of the report, collect any more evidence, and agree with how the incident is categorised or make an alternative recommendation.<sup>354</sup>

The report is then subjected to a ‘Management Assessment’.<sup>355</sup> Neither the *AYDC Incident Reporting Procedure* nor the *AYDC Incident Reporting* form has been updated to reflect the disbandment of the Centre Support Team and the establishment of the Risk Assessment Process Team and Weekly Review Meeting—both the form and procedure continue to refer to the Centre Support Team and its role in reviewing incidents.<sup>356</sup>

The Management Assessment considers the level of seriousness of the incident, identifies whether a conference is needed, identifies whether one or more authorities or people should be notified (for example, the police, Child Safety Services or a young person's parents), and whether any other actions are required (such as a program referral or an independent investigation).<sup>357</sup>

The policy provides that the Director, Strategic Youth Services, confirms whether to proceed with an independent investigation.<sup>358</sup> In the new Department for Education, Children and Young People, the Director, Custodial Operations, chairs a weekly Incident Review Committee meeting at which all incidents are reviewed.<sup>359</sup> The Director, Custodial Operations, refers matters on for further investigation.<sup>360</sup>

As described, the Risk Assessment Process Team considers incidents that fall into particular categories of seriousness. Incident reports are also read by the Chair of the Weekly Review Meeting.<sup>361</sup>

## 5.7 Dealing with a detention offence

Section 140 of the Youth Justice Act outlines the way in which detention offences should be handled. Section 140(2)(b) of the Act requires that, before a complaint may be filed in respect of a detention offence that an offender admits committing, the Secretary must be notified of the offence. The Secretary must, where practicable:

- confer with the offender, a guardian (unless one cannot be found after reasonable enquiry) and any other person whose participation the Secretary considers is likely to be beneficial in determining how to deal with the offence
- consider how the offence should be dealt with.<sup>362</sup>

After doing so, the Secretary may:

- suspend further action, 'on the undertaking of the offender to be of good behaviour for a period not exceeding 2 months'
- caution the offender
- delay the offender's release by no more than three days, and/or
- file a complaint against the offender.<sup>363</sup>

The Youth Justice Act requires that a conference be held where practicable.<sup>364</sup> *Standard Operating Procedure No. 24: Conferencing* describes conferencing as 'an opportunity for both the offender and victim to enter a restorative discourse and for the offender to take responsibility for their behaviour and to make appropriate reparation'.<sup>365</sup> *Standard Operating Procedure No. 24* provides that sanctions may result from a conference, such as a 'good behaviour bond'.<sup>366</sup>

We understand that, for a conference to be held, the offender must admit to the offence and agree to participate in the conference.<sup>367</sup> If possible, the conference should involve the victim-survivor, a support person, a guardian and appropriate staff representatives.<sup>368</sup>

As of March 2022, Secretary Pervan delegated his functions with respect to dealing with a detention offence to the Deputy Secretary, Children, Youth and Families, the Director, Youth and Family Violence Services, the Centre Manager, the Assistant Manager and (to a more limited extent) the Operations Manager and the Coordinator, Training and Admissions.<sup>369</sup>

## 5.8 Oversight of youth detention in Tasmania

As highlighted by the National Royal Commission, external oversight bodies play a critical role in responding to allegations of child sexual abuse. The National Royal Commission recognised that external oversight bodies facilitate transparency and accountability and can have a positive impact on organisational culture, changes in policy and practice, and the capacity of an institution to implement best practice.<sup>370</sup> The National Royal Commission also observed that, in jurisdictions that do not have independent oversight arrangements, there was significantly less publicly available information about the youth detention system.<sup>371</sup>

The National Royal Commission recommended that risks of child sexual abuse associated with youth detention centres be mitigated by preventive monitoring and independent oversight by custodial services, community visitor schemes, Ombudsman's offices and children's commissioners and guardians.<sup>372</sup> The primary independent oversight mechanisms for youth detention in Tasmania are the Ombudsman, the Commissioner for Children and Young People, the Custodial Inspector and the National Preventive Mechanism under OPCAT. We describe these mechanisms and discuss ways to strengthen the oversight of youth detention in Chapter 12.

# 6 Previous reviews into Ashley Youth Detention Centre

The evidence and material available to our Commission of Inquiry included no less than 17 internal and external briefings, reports and reviews about Ashley Youth Detention Centre since 2003. While few of these briefings, reports and reviews directly considered child sexual abuse at the Centre, they all identified problems affecting the safety of young people in the detention environment. This section summarises the most relevant briefings, reports and reviews into Ashley Youth Detention Centre.

The summaries of these separate documents may seem repetitive. That is because they are. It was apparent to us when reviewing them that successive Tasmanian governments have repeatedly and consistently been made aware of persistent systemic issues in the treatment of children and young people detained at Ashley Youth Detention Centre and failed to achieve sufficient meaningful change to address those issues. Information we received through our Inquiry further suggests that many of the problems highlighted in these briefings, reports and reviews have persisted at Ashley Youth Detention Centre and continue to increase the risk of child sexual abuse. The language in the reports describes behaviour using euphemisms such as ‘inappropriate strip searching’ or ‘punitive’ approaches. Considering the international and domestic standards described previously in this chapter, these behaviours can only be described as human rights violations.

## 6.1 Abuse in State Care Program (July 2003)

In 2003, the Tasmanian Government announced a review of claims of abuse from adults who had been in state care as children, including youth detention.<sup>373</sup> The announcement followed media coverage about a man who alleged he had been sexually abused as a child by his foster parent, who was a convicted paedophile.<sup>374</sup>

The review was undertaken by the Tasmanian Ombudsman in cooperation with the Department of Health and Human Services.<sup>375</sup> The scope of the review was broad—it applied to allegations of abuse in state care in Tasmania, including in youth detention, with no qualifying period.<sup>376</sup> After the review started, the Tasmanian Government announced that ex gratia payments of up to \$60,000 would be available to eligible claimants who had suffered abuse in state care and that an independent assessor had been appointed to prepare a report and make decisions about individual cases.<sup>377</sup>

This program, called the Abuse in State Care Program, operated in four rounds from 2003 to 2013.<sup>378</sup> Specific details of the nature of the abuse alleged at the Centre and at Ashley Home for Boys, and the outcomes of individual claims, were not publicly reported.<sup>379</sup>

According to reports published on the various rounds of the Abuse in State Care Program (which varied in the level and type of information they provided about claims):

- During the first round, which ran from 2003 to 2004, 32 people made claims about abuse that occurred at Ashley Home for Boys.<sup>380</sup> The report described, in general terms, that most of these claims related to ‘sustained physical and emotional abuse’, with allegations of sexual abuse described as ‘less common’ in boys’ homes (including Ashley Home for Boys).<sup>381</sup>

- In the second round, which ran from 2005 to 2006, 117 claimants came forward about abuse that occurred at Ashley Home for Boys.<sup>382</sup> We are unclear what type of abuse these claims relate to but note that, across all claims made in this period, 189 (or 45 per cent) related to sexual abuse.<sup>383</sup>
- There were 995 claims (in total) made in the third round, which ran from 2007 to 2010. We have not been able to identify the number of claims that were made about Ashley Home for Boys or Ashley Youth Detention Centre because a detailed report relating to this third round of claims was not available (we drew the 995 figure from the report of the fourth round of claims).<sup>384</sup>
- The fourth round of the program, which ran from 2011 to 2013, resulted in 172 claims against Ashley Home for Boys and Ashley Youth Detention Centre.<sup>385</sup> We are unsure what proportion of these claims relate to sexual abuse but note that, across all 199 claims of sexual abuse, nearly 50 per cent were made by claimants who were placed in an institution.<sup>386</sup>

When the program wound up in 2013, it was replaced by the Abuse in State Care Support Service.<sup>387</sup> We discuss the Abuse in State Care Program and the Abuse in State Care Support Service, and the nature of the claims made about Ashley Youth Detention Centre, in Chapter 11, Case studies 1 and 7, and in Chapter 12.

## 6.2 Review for the Secretary, Department of Health and Human Services (September 2005)

In 2005, following reports of assaults on two young people at Ashley Youth Detention Centre by other young people detained there, the Secretary of the Department of Health and Human Services established a review team to examine the robustness of systems and protocols at the Centre, and the effectiveness of those systems in ensuring the safety and wellbeing of detained young people.<sup>388</sup> The review team consisted of the Commissioner for Children and Young People and two senior departmental officers.<sup>389</sup> The review was to specifically examine the Centre's systems for minimising abuse towards children and young people by other 'residents' or staff, for reporting allegations of abuse, and for responding adequately and in a timely manner to allegations of abuse.<sup>390</sup>

The review team identified several problems and made 23 recommendations, including the following:<sup>391</sup>

- There were varying levels of intimidation, from bullying to violence, among residents.<sup>392</sup> The review team recommended that accommodation unit allocations be reviewed based on the mixture of residents at the Centre.<sup>393</sup>

- Physical blind spots impeded effective monitoring of residents and therefore affected the Centre’s ability to provide a safe environment. The review team recommended that these blind spots be assessed, and solutions implemented, along with a 12-month trial of closed-circuit television in one of the accommodation units.<sup>394</sup>
- There was a need for documented procedures to manage incidents and complaints.<sup>395</sup> The review team acknowledged that children and young people in detention may not report incidents due to fear of retaliation or ridicule, and due to their lack of confidence that complaints would be effectively managed. The review team also found that residents did not have access to independent people from outside the Centre with whom they could discuss issues and concerns.<sup>396</sup> The review team recommended that the complaints processes at the Centre be revised and that an Ashley Youth Detention Centre Residents’ Advocate position be created in the Office of the Commissioner for Children and Young People.<sup>397</sup>

There was no clear response from the Tasmanian Government to these recommendations at the time. We note that, from February 2022, the Commissioner for Children and Young People has had an advocacy role in place for children and young people in detention.<sup>398</sup> The Commissioner’s *2020–2021 Annual Plan* states that a function of this role is to regularly visit Ashley Youth Detention Centre.<sup>399</sup> We also note that the Tasmanian Government’s most recent Annual Progress Report in response to recommendations of the National Royal Commission states that an Advocate for Young People in Detention, employed by the Commissioner for Children and Young People, ‘is present within the Centre as an independent person with whom the young people can speak ... including to discuss any concerns or complaints’.<sup>400</sup>

It is unclear to us when closed-circuit television was introduced at Ashley Youth Detention Centre. Media reports indicate that closed-circuit television footage was used as evidence in relation to a staff member who allegedly assaulted two detainees at the Centre in July 2016.<sup>401</sup> The Custodial Inspector’s *Annual Report 2019–20* states that, following an inspection, more cameras had been added to known blind spots, and that more cameras would be installed as part of the Centre’s redevelopment.<sup>402</sup>

### 6.3 Ashley, Youth Justice and Detention Report, Legislative Council Select Committee (2007)

In 2007, a Legislative Council Select Committee was established amid concerns that previous reviews had failed to resolve longstanding problems at Ashley Youth Detention Centre, and that rehabilitation rates for children and young people in detention had not improved.<sup>403</sup> In its report, the Committee stated that:



The system is under stress. Security is lax, contraband enters the site illegally and management struggles to maintain a well-trained, professional, and committed staff. From time to time there are violent aggressive episodes involving both residents and staff. There is a need to maintain a secure unit.<sup>404</sup>

The Committee made 32 recommendations to improve the youth justice system. Recommendations specifically relating to Ashley Youth Detention Centre included that the Government acknowledge the cost-effectiveness of diverting young people away from detention, that attendance at the Centre's school be mandatory, that the low morale among employees be addressed, that only female workers supervise female detainees and that the Centre be renamed Ashley Secure Care Centre.<sup>405</sup>

The Tasmanian Government's response in 2008 indicated that:

- Six of the recommendations were not supported. These recommendations were about amending the Youth Justice Act to allow access to diversionary programs before any guilty plea, creating supported accommodation for children on remand, creating dedicated youth justice magistrates, re-establishing a secure unit at the Centre separate from the rest of the facility and renaming the Centre.
- Twenty-six recommendations were in progress, under review, supported or had been actioned. They included those relating to improved bail and remand options for children, increased funding and support for the community service order system and youth justice programs, improved early intervention and prevention programs for children at risk of entering the youth justice system, improved diversionary opportunities (including for Aboriginal children), improved access to educational opportunities, improved staff recruitment and training, consistent implementation of standard operating systems and improved support for staff who experience adverse incidents.<sup>406</sup>

## 6.4 Reviews following the death of Craig Sullivan in detention at Ashley Youth Detention Centre

On 25 October 2010, Craig Sullivan died in his room while on remand at Ashley Youth Detention Centre.<sup>407</sup> He was 18 years old.<sup>408</sup> In the weeks before his death and before his admission to Ashley Youth Detention Centre, Craig was involved in a car accident.<sup>409</sup> On 8 October 2010, while at the Centre, Craig was the victim of an assault by another detainee. During this assault, he was punched in the head and subjected to at least one, and possibly two, forceful headbutts.<sup>410</sup> In the days before his death, Craig had vomited multiple times and had complained of headaches to other young people detained at the Centre and to a number of staff.<sup>411</sup> At the inquest into Craig's death, there was evidence before the Coroner that staff at the Centre had provided Craig with a mop and bucket, with the 'somewhat callous' expectation that he would clean up his own vomit. It appears



that Craig did this the evening before he died.<sup>412</sup> After being monitored intermittently by Centre staff through the weekend, Craig was found unresponsive after he failed to come out of his room for breakfast on Monday morning.<sup>413</sup>

Following Craig's death, the Department commissioned two reviews—a clinical assessment and a serious incident investigation.<sup>414</sup> These reviews were completed and reported before the coronial inquest into Craig's death. After the coronial inquest, the Coroner considered that all the recommendations of the Clinical Assessment Report and the Serious Incident Investigation Report were appropriate, and therefore adopted them as recommendations for the coronial inquest.<sup>415</sup> The Coroner also made additional recommendations.

We summarise the findings and recommendations of the two reports and the Coroner in the sections that follow.

#### **6.4.1 Clinical Assessment Report (November 2010)**

Following Craig's death, the Minister for Children requested that the Chief Health Officer undertake a clinical assessment of Ashley Youth Detention Centre's policies and protocols for health issues.<sup>416</sup> The Chief Health Officer's report, *Clinical Assessment of Ashley Youth Detention Centre's Current Policy and Protocols for Health Issues* ('Clinical Assessment Report'), dated 30 November 2010, listed recommendations including that clinical support and governance arrangements be established with the Department of Health and Human Services' Correctional Primary Health Services; young people in detention have access to the same standard of health care as the wider community; clinical advice and assessment be available 24 hours a day; standard operating procedures relevant to clinical matters be updated; and clinical staffing levels be increased.<sup>417</sup>

#### **6.4.2 Serious Incident Investigation Report (March 2011)**

The Department of Health and Human Services also established a Serious Incident Investigation Committee to examine the specific circumstances of Craig's death.<sup>418</sup>

The committee's report, *Serious Incident Investigation Report Ashley Youth Detention Centre—Death of a Youth on Remand* ('Serious Incident Investigation Report'), was issued on 30 March 2011.<sup>419</sup> It appears that the report was left in 'final draft' form.

Although the committee was primarily tasked with investigating Craig Sullivan's death, the report included examples of other instances where the health and wellbeing of Ashley Youth Detention Centre detainees were placed at significant risk.<sup>420</sup>

The committee's findings, as documented in its report, included that:

- There was a failure to recognise the need for and/or seek further clinical advice after Craig was assaulted.<sup>421</sup>
- Despite Craig's long history of engagement with Youth Justice and the Department of Health and Human Services, his specific needs were not addressed in a comprehensive or coordinated way.<sup>422</sup>
- There was a lack of risk-based decision making by Centre staff.<sup>423</sup>
- The youth workers at the Centre were unprofessional, with no formal approach to caring for young people in detention.<sup>424</sup>
- The Centre failed to provide humanitarian conditions to young people.<sup>425</sup>
- The practices and behaviours at the Centre were in breach of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, which require that 'every child who is ill or complains of illness ... should be promptly examined by a medical officer'.<sup>426</sup>
- The Centre lacked accessible 24/7 healthcare services or on-call clinical advice.<sup>427</sup>
- The training provided to Centre staff was inadequate for responding to critical incidents.<sup>428</sup>
- Not all staff had completed the induction program and there was no ongoing culture of education and training. While there had been some changes to recruitment processes, 'there is a strong likelihood the pervading cultural norms and practices may be undermining this' change.<sup>429</sup>
- Operating protocols, including for emergency response, were not routinely complied with, and 'a system of "custom and practice" rather than rules based behaviour may exist'.<sup>430</sup>
- There was a lack of preparedness for a death in custody and foresight that such an event might happen.<sup>431</sup>
- The physical design of the Centre building created several problems, including that sick children and young people were locked in their cells because there was no space for a sick room or hospital bed. The ability to observe sick children and young people while they were in their cells was very limited.<sup>432</sup>
- 'There is a lack of continuity of care or information between teams, units, individuals and shifts that has resulted in key information not being passed on to relevant staff in a timely manner'.<sup>433</sup> This included failures in communicating information about Craig's car accident and the assault.<sup>434</sup> There was also no ability for key information or healthcare requirements to be reliably communicated

or followed up, and no system for ensuring reliable ongoing communication between health and custodial services.<sup>435</sup> Part of this was attributed to communication being paper based.<sup>436</sup>

- There was a general lack of respect for, or value attached to, communication with families, including parents, of detainees.<sup>437</sup>
- The provisions for clinical governance and oversight of Centre health and wellbeing services were inadequate.<sup>438</sup>

The report also documented several specific findings concerning the Ashley Youth Detention Centre Health Service, including:

- The health service was inadequate in the areas of after-hours clinical advice and response; facilities for observing young people who were unwell or sick; clinical assessment and treatment of young people affected by drugs and alcohol on admission; prompt access to necessary medications; contemporary youth health needs assessment, care planning and treatment services; and linkages to external services. The health service ‘readily devolves its responsibility for medical care to untrained people with manifestly inadequate skills and abilities to deliver medical care’.<sup>439</sup>
- The recommendations from the 2002 health service review at the Centre had not been implemented, and no other review of the adequacy of health services had been completed since then.<sup>440</sup>
- Health facilities and equipment were inadequate and did not meet Australian General Practitioner Accreditation and Licensing requirements.<sup>441</sup>
- The Centre’s location in Deloraine reduced young people’s access to health care.<sup>442</sup>
- ‘Systems in place for medication management are not adequate. Routine medication is primarily delivered by youth workers and not nursing staff. The ability to obtain urgent prescriptions and medications is limited due to the lack of a medical practitioner after hours, which puts at risk any immediate or urgent after-hours medication response’.<sup>443</sup>
- ‘Management of chronic health conditions such as Insulin Dependent diabetes or asthma is compromised after the nurse has left the facility as there is no on-call procedure’.<sup>444</sup>

The key recommendations of the Serious Incident Investigation Report included that:<sup>445</sup>

- the philosophy and model of care for youth detention be reviewed<sup>446</sup>
- immediate action be taken to address concerns about the culture at the Centre<sup>447</sup>

- the youth worker role at the Centre be reviewed, including to ensure the role encompasses youth health and wellbeing interventions as well as custodial responsibilities, and includes developing basic clinical assessment and observation skills to support onsite management of ill or injured young people<sup>448</sup>
- standard operating procedures, and lack of compliance with those standard operating procedures, be reviewed<sup>449</sup>
- the Centre’s health service be improved, including through implementing the Clinical Assessment Report recommendations<sup>450</sup>
- communication systems at the Centre be reviewed and improved, including by implementing an effective system of shift handover to ensure timely communication of all relevant information<sup>451</sup>
- respectful engagement and communication with young people’s parents and significant others be mandated in the policy framework, and operations, of the Centre.<sup>452</sup>

Professor White, a member of the Serious Incident Investigation Committee between late 2010 and 2011, gave evidence to us about the response of authorities following Craig’s death.<sup>453</sup> He characterised the findings of the investigation as ‘damning’ of operations at Ashley Youth Detention Centre ‘on all levels’.<sup>454</sup>

### 6.4.3 The Department’s response to the Clinical Assessment Report and the Serious Incident Investigation Report

A Department of Health and Human Services report, *Ashley Youth Detention Centre Overview Report* (‘Overview Report’), dated August 2013, provides commentary on the progress that had been made on implementing the recommendations set out in the Clinical Assessment Report and the Serious Incident Investigation Report.<sup>455</sup>

It notes that, in April 2011, the former Department of Health and Human Services established two governance bodies to progress the reforms to Ashley Youth Detention Centre recommended after Craig’s death:<sup>456</sup>

- A Reform Steering Committee, chaired by the Deputy Secretary for Children, was charged with overseeing the implementation of the Clinical Assessment and Serious Incident Investigation Report recommendations.<sup>457</sup>
- The Review and Monitoring Team was tasked with verifying implementation of the reforms.<sup>458</sup> The Reform Steering Committee provided progress reports to the Review and Monitoring Team.<sup>459</sup> The Review and Monitoring Team used site visits and a detailed desktop audit to verify progress.<sup>460</sup>

The Overview Report noted that there had been progress towards implementing the recommendations, but there were still areas requiring action, including to staff training and health assessments, and monitoring to improve the Centre's emergency management response.<sup>461</sup>

Professor White was appointed to the Review and Monitoring Team. He explained that, as part of implementing the investigation's recommendations in 2011 and 2012, the management team at Ashley Youth Detention Centre redesigned and redrafted standard operating procedures, in particular for how vulnerable young people in detention would be identified and supported.<sup>462</sup> Professor White told us that the work and purpose of the Review and Monitoring Team in improving Ashley Youth Detention Centre was ultimately undermined by the lack of senior departmental support for substantive change and by the monitoring team's dissolution.<sup>463</sup> He gave evidence that about 18 months after the Review and Monitoring Team was created, its work stopped 'abruptly' following the shift of the executive lead in the Department of Health and Human Services, who had oversight of the project, to another area.<sup>464</sup> Professor White told us that while it was not communicated to him at the time, he believed there may have been an intention by senior members of the Department of Health and Human Services to end the work of the Review and Monitoring Team.<sup>465</sup>

When asked whether the Review and Monitoring Team's role had been completed at the time the team was effectively dissolved, Professor White replied:

No. And, in fact, one of the clear things that—and we were quite keen to keep the monitoring going—one of the clear things was that it had to be a continuous process well into the future, because that was the way to have culture change ... you can have a whole bank of new standard operating procedures, but if you don't do your monitoring and auditing, then they can just be ignored like the previous ones were.<sup>466</sup>

#### **6.4.4 Coroner's report (November 2013)**

The Coroner found that Craig's death was caused by an abscess rupturing in his brain.<sup>467</sup> The Coroner could not conclusively rule out either the car accident or assault in detention as contributing to the abscess, describing their potential contribution as 'possible, but less likely' causes than the extension of a sinus infection.<sup>468</sup>

The Coroner did find that the assault on Craig at Ashley Youth Detention Centre was 'clearly capable of causing a head injury'.<sup>469</sup> The Coroner also found that, based on Craig's symptoms, he should have been referred for a medical assessment by a doctor the evening before he died.<sup>470</sup> The Coroner further found that Craig's death would likely have been avoided if he had received medical attention before the rupture of the brain abscess.<sup>471</sup> As stated in the Coroner's report, '[d]espite evidence that Craig was unwell, particularly during the weekend prior to his death, he was not referred for medical assessment and treatment'.<sup>472</sup>

When adopting the recommendations of the Clinical Assessment Report and the Serious Incident Investigation Report, the Coroner noted that some of the recommendations had been substantially implemented, while others had ‘not yet been implemented at all’.<sup>473</sup>

As well as adopting the recommendations from the two reports, the Coroner made a number of other recommendations in November 2013. These included:

- All staff should undertake training to ensure rigorous compliance with the requirement to obtain medical review of children and young people who complain of being or who appear to be unwell. This recommendation was made as a result of the Coroner’s finding that the Operations Coordinator at Ashley Youth Detention Centre at the time of Craig’s death did not understand the relevant standard operating procedure.<sup>474</sup>
- All matters relevant to a detainee’s health should be recorded in a way that ensures they are communicated and available to the staff responsible for the care and supervision of children and young people and for medical personnel reviewing detainees.<sup>475</sup>

Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that, immediately following Craig Sullivan’s death, the Chief Health Officer carried out a clinical assessment of policy and protocols for providing health services and the ensuing report contained recommendations, all of which were implemented by November 2013.<sup>476</sup> These included transferring the functions of the Ashley Youth Detention Centre Health Service to the former Department of Health and Human Services’ Correctional Primary Health Services, increasing nursing capacity and establishing a healthcare information system to store and share all client information in one place.<sup>477</sup>

## 6.5 Independent Review of Ashley Youth Detention Centre, Tasmania, Heather Harker, Metis Management Consulting (June 2015)

In 2014, the Deputy Secretary, Children and Youth Services commissioned an independent review of Ashley Youth Detention Centre. The purpose of the review was to inquire into a range of resource and operational matters, including increases in workers compensation claims, how to manage absences from work due to sickness (and therefore potentially excessive use of casual staff) and the extent to which these matters affected the Centre’s philosophy and operational model.<sup>478</sup> The reviewer, Heather Harker, met with staff, detainees, family members of detainees and other stakeholders, and considered a range of materials including reports and memorandums.<sup>479</sup>

In her report, Ms Harker commented on the long tenure of staff and found that this had established a certain culture at the Centre. Ms Harker also expressed concern about ‘a lack of governance and management presence, direction and scrutiny in a number of critical areas that have a specific impact on the Centre’s budget and daily operations’.<sup>480</sup>

The report described a culture that leaned more towards punishment than restoration and rehabilitation, and a preference for using force to manage children and young people in detention rather than techniques taught in training, which focused on de-escalation.<sup>481</sup> The report also referred to a culture of ‘passive resistance’ to change.<sup>482</sup>

Also, Ms Harker found:

- There were poor living conditions for children and young people, along with ‘wholly unacceptable’ visiting facilities.
- There was little meaningful interaction between young people and the youth workers who supervised them.
- There was a lack of visibility and communication from leadership and senior management.
- There were concerns about some staff members’ behaviour towards other staff, visitors and detainees.<sup>483</sup>

Ms Harker called for a ‘more assertive’ stance to addressing these problems and more active complaints management.<sup>484</sup> She made 13 recommendations covering budgetary compliance, staff rostering, management of workers compensation, and leadership and training—this included the need for ‘strong visible leadership’ to achieve ‘accountability for professional practice and daily operations’.<sup>485</sup>

When the report was released in 2015, a year after its delivery to the Tasmanian Government, the Human Services Minister stated that a cultural change process, as well as additional training on risk management and intervention, had been implemented at the Centre, and that the Government had commissioned a youth detention options paper (discussed in Section 6.6).<sup>486</sup>

## 6.6 Custodial Youth Justice Options Paper: Report for the Department of Health and Human Services, Noetic Solutions Pty Ltd (October 2016)

In 2016, the Tasmanian Department of Health and Human Services engaged Noetic Solutions Pty Ltd (‘Noetic’) to develop an options paper setting out potential custodial youth justice models.<sup>487</sup>



Noetic undertook extensive research and consulted with the Department of Health and Human Services and external stakeholders, including young people in detention at the time, to understand the current and future needs of the custodial youth justice system in Tasmania.<sup>488</sup> One of the issues revealed by consultations was that staff at Ashley Youth Detention Centre were sceptical of a therapeutic approach to managing young people in detention:

Some AYDC staff see a therapeutic approach as an ineffective deterrent for young people, which are considered by them to be less successful than a risk-based approach. These staff see this approach as removing useful strategies for managing young people's challenging behaviour. For example, staff saw the strategy of using isolation of young people when angry or upset as an effective means of mitigating a potentially unsafe situation.<sup>489</sup>

After reviewing the existing custodial model at Ashley Youth Detention Centre, Noetic provided four options for a new custodial youth justice model and stated that any model should be underpinned by trauma-informed practice and a therapeutic approach.<sup>490</sup>

The options were to:

- upgrade the existing Centre
- maintain the Centre and construct an additional, smaller purpose-built facility
- establish a single purpose-built secure detention facility
- establish two purpose-built secure detention facilities.<sup>491</sup>

Noetic recommended the fourth option—that the Tasmanian Government build two detention facilities—one in Hobart and the other in Launceston. Noetic proposed that each facility have a 12-bed capacity, noting that rates of youth offending and incarceration had recently declined.<sup>492</sup> The data available to Noetic showed that between 2008–09 and 2014–15 the number of youth offenders in Tasmania had declined by 47 per cent. Noetic projected that by 2020 there would be 90 young people on community-based supervision orders and six young people in detention at any given time.<sup>493</sup>

The options paper highlighted:

- Ashley Youth Detention Centre cost more than \$9.4 million a year to operate, despite only accommodating about 10 children or young people on any given day.<sup>494</sup>
- Therapeutic or trauma-informed care was not being practised at the Centre.<sup>495</sup>
- The average cost of accommodating a young person at the Centre was \$3,562 per day, which was 2.5 times the national average of \$1,391 per day.<sup>496</sup>



- Tasmania’s recidivism rates showed that most children or young people reoffended within 12 months of their release from detention, demonstrating that the existing custodial model did not divert young people from the system.<sup>497</sup>
- Key challenges for the Centre were managing the use and scalability of a large facility with fixed costs and providing rehabilitation opportunities to a small number of young people with complex needs.<sup>498</sup>
- The Centre’s location made it difficult to provide the full range of services required to support the complex needs of children and young people in detention.<sup>499</sup>

The Tasmanian Government decided not to proceed with Noetic’s preferred and recommended option, instead announcing in June 2018 that it would commit \$7.3 million to upgrading Ashley Youth Detention Centre.<sup>500</sup> In commenting on this choice of action, the Minister for Human Services was quoted as saying: ‘We have sought to balance the needs of youth offenders with the importance of the [Ashley Youth Detention Centre] facility and the 60 jobs in the Deloraine community’.<sup>501</sup>

We note that the Government has now committed to closing Ashley Youth Detention Centre and establishing several new youth justice facilities, although in July 2023 the Government cast doubt on its earlier commitment to close the Centre by the end of 2024.<sup>502</sup> We discuss the closure of Ashley Youth Detention Centre in Chapter 12.

## 6.7 Reviews of use of force incidents (2016–19)

On 14 and 15 July 2016, a series of incidents occurred at Ashley Youth Detention Centre during which detainees were alleged to have damaged property at the Centre, including kicking doors, breaking windows and wielding pieces of broken glass. While the incidents raised issues with respect to worker safety, there were also concerns in relation to the use of force and isolation by Centre staff in managing the incidents.<sup>503</sup> We are aware of three reports prepared in response to the incidents: a Report to the Minister for Human Services (August 2016), a Critical Incident Investigation Report prepared by the Department of Health and Human Services (undated) and a WorkSafe Tasmania report (February 2017).<sup>504</sup>

Further incidents involving the use of force occurred in November and December 2017, during which detainees were restrained by Ashley Youth Detention Centre staff and one young person was placed in isolation because of a perceived threat that he would assault other young people and staff.<sup>505</sup> In 2018, the Department of Health and Human Services initiated an internal review of these incidents.<sup>506</sup> In 2019, the Tasmanian Ombudsman completed a preliminary inquiries report into one of the 2017 incidents in response to a complaint received from a young person in detention about the use of force by Centre staff.<sup>507</sup>

In the following sections, we outline the main findings from these five reports as they relate to the use of force at Ashley Youth Detention Centre.

### **6.7.1 Report to the Minister for Human Services from the Department of Health and Human Services (August 2016)**

A report prepared by the Department of Health and Human Services for the Minister for Human Services about the 14 and 15 July 2016 incidents examined the possible use of excessive force, with a particular focus on the actions of one youth worker against children and young people in detention during the incidents.<sup>508</sup>

The report noted that, while the youth worker had been trained in non-violent crisis intervention, the restraints used were not consistent with the manual.<sup>509</sup> The report also noted that the use of force appeared to be ‘excessive to that which might be considered reasonable’, given that the young person was seen calmly sitting before the use of force.<sup>510</sup>

The report contained the following actions to be undertaken:

- immediate action in relation to the youth worker, including Employment Directions No. 4 and No. 5 processes, appointing an appropriate independent investigator and a request for the worker to be absent from the workplace on full pay<sup>511</sup>
- a change-management process, including allocating \$300,000 to appoint a senior change manager and to develop a training package<sup>512</sup>
- developing a WorkSafe Corrective Action Plan<sup>513</sup>
- continuing to roll out a Children and Youth Services review of priority practices and procedures<sup>514</sup>
- developing a process to ensure timely review of all critical incidents<sup>515</sup>
- delivering risk assessment training in August 2016<sup>516</sup>
- developing a proposal to strengthen the use of multidisciplinary teams to support a ‘therapeutic informed approach’.<sup>517</sup>

The Secretary of the Department referred the conduct of the staff member in question to Tasmania Police, suspended the staff member on full pay under Employment Direction No. 4 and started a formal process pursuant to Employment Direction No. 5, to run in parallel with the Tasmania Police investigation.<sup>518</sup> Ultimately, the disciplinary process resulted in counselling, a reprimand and a temporary reassignment of duties.<sup>519</sup>

### **6.7.2 Critical Incident Investigation Report (undated)**

The Department of Health and Human Services prepared a Critical Incident Investigation Report for WorkSafe Tasmania in relation to the incidents on 14 and 15 July 2016.<sup>520</sup>

The report categorised the events as five separate incidents and it reviewed footage, policy and procedure documents, investigation reports and witness statements.<sup>521</sup> It noted difficulties due to delays in receiving statements from staff, inconsistencies between individual statements, lack of closed-circuit television coverage in certain areas in the Centre and lack of audio accompanying the closed-circuit television footage.<sup>522</sup>

The report's findings included:

- Despite statements from staff suggesting that they feared for their safety and the detainees were acting in a 'riotous manner', no staff member activated their duress alarm or called a 'code black' in accordance with the relevant standard operating procedures.<sup>523</sup>
- The actions of staff were 'contrary to policy' and identified an organisational deficiency.<sup>524</sup>
- The actions of staff highlighted deficiencies in staff training and staff capability in relation to emergency response, risk reduction, de-escalation of violent behaviour and sound decision making to support proactive risk awareness and safety.<sup>525</sup>
- The closed-circuit television footage did not appear to reveal the use of de-escalation strategies.<sup>526</sup>
- The restraint used by youth workers did not comply with non-violent crisis intervention training.<sup>527</sup>

### 6.7.3 WorkSafe Tasmania Investigation Report (February 2017)

WorkSafe Tasmania also conducted an investigation into the 14 and 15 July incidents.<sup>528</sup> The investigation report indicated that several factors led to significant deficiencies in Ashley Youth Detention Centre's safety management system. These factors were 'training, consultation, resourcing, communication and, particularly, risk identification and effective management and control'.<sup>529</sup> The report noted 'the use of isolation, the use of force, and the provision of a less institutionalised appearance within the facility' were factors that contributed to the incidents on 14 and 15 July 2016.<sup>530</sup>

WorkSafe Tasmania indicated that, while it recommended that no prosecution action be taken against any party, the Secretary of the Department of Health and Human Services (Secretary Pervan) was required to provide monthly status reports in relation to the implementation of a remedial corrective action plan and a comprehensive safety management plan.<sup>531</sup> The remedial corrective action plan included, as a high priority, to:

... review, evaluate and reinforce the agenc[y's] culture. Ensuring compliance with the programme, policies and procedures (change-management process identified and approved) [within 12 months].<sup>532</sup>

#### 6.7.4 Department of Health and Human Services Review of Incidents at Ashley Youth Detention Centre (2018)

The Department of Health and Human Services initiated an internal review of the use of force in response to incidents that occurred at Ashley Youth Detention Centre in November and December 2017.<sup>533</sup> An Incident Review Committee was established and the committee's report included recommendations relevant to the use of force and staff practices including:

- Any incident that had a use of force component was to be downloaded from the closed-circuit television footage in its original form and securely stored on a separate drive.<sup>534</sup>
- More training and information sessions were to be provided on isolation procedures and relevant delegations.<sup>535</sup>
- There should be greater clarity in the Supervision and Movement of Young People standard operating procedure about the required numbers of staff when moving compliant and noncompliant children and young people in detention.<sup>536</sup>
- Ashley Youth Detention Centre should be provided with its own training budget; a fixed-term position for a training manager should be created as a matter of urgency; the training manager should undertake a full audit of the training for each staff member; a permanent position for a training facilitator and assessor at the Centre should be created; and the possibility of professional qualifications for all employees at the Centre should be explored.<sup>537</sup>
- Discussions should be held with onsite management, providing clear guidelines and clarifications about their roles and responsibilities for managing employees, including their ongoing professional development.<sup>538</sup>
- The Centre Manager must review every incident involving the use of force.<sup>539</sup>
- Future legislative amendments should consider changing the definition of the word 'isolation'.<sup>540</sup>
- All staff were to be trained and undertake regular review training in verbal judo or similar de-escalation techniques and motivational interviewing techniques by suitably qualified people.<sup>541</sup>
- A Use of Force Review Committee should be established, and a proportion of all incidents should be reviewed by the committee. This committee should have a maximum of four people and include representatives from the following areas:
  - the Centre's Training Manager or representative from Professional Services
  - Human Resources

- Workplace Health and Safety
- Quality Improvement and Workforce Development.<sup>542</sup>

We understand the Human Resources, Workplace Health and Safety, and Quality Improvement and Workforce Development units were based in the Department of Health and Human Services and not Ashley Youth Detention Centre.

The Department decided that no action would be taken against the staff members involved in these incidents ‘due to gaps in training and procedures’ at the Centre.<sup>543</sup>

### **6.7.5 The Ombudsman’s preliminary inquiries into the assessment of a use of force incident (December 2019)**

In December 2019, the Tasmanian Ombudsman, Richard Connock, provided a preliminary inquiries report to Secretary Pervan after receiving a complaint from a detainee about excessive use of force by staff at Ashley Youth Detention Centre in December 2017.<sup>544</sup>

In his report to the Secretary, Mr Connock questioned the quality and thoroughness of the Department’s 2018 internal review (referred to earlier), describing it as ‘perfunctory’.<sup>545</sup> Among other criticisms of the internal review, Mr Connock stated that the Department had failed to gather basic evidence to inform its assessment of the use of force against the young person who had complained to him, including speaking to that young person about his version of events, detailing any injuries that the young person may have suffered and reviewing what training on the use of force had been provided to youth workers at Ashley Youth Detention Centre.<sup>546</sup> Mr Connock also noted that the internal review had not included an assessment of whether the use of force was excessive against criteria in the Youth Justice Act relevant to what constitutes ‘reasonable force’.<sup>547</sup>

Mr Connock also noted in his report to the Secretary that the Department had been aware for some time that there were gaps in the training of staff members at the Centre in relation to the use of force.<sup>548</sup> Mr Connock emphasised that an independent review of Ashley Youth Detention Centre, undertaken in 2015 (refer to Section 6.5), had identified that:

A number of people who are involved in the training of youth workers expressed concerns at youth workers preferring to use physical means of dealing with young people rather than the de-escalation techniques emphasised in the training.<sup>549</sup>

Mr Connock also emphasised that documentation relevant to a therapeutic change program adopted by Ashley Youth Detention Centre before 2016, known as the ‘Ashley+ Approach’, had included significant investment in training, but that such training was not working:

In December 2016, there was a majority of youth workers and staff [at Ashley Youth Detention Centre] with 10+ years experience in the Centre. The majority of these staff were originally trained for a corrections rather than a therapeutic environment. The training and the transition over recent years from a corrections focus to a rehabilitation and therapeutic focus are often at odds and despite significant training some staff continue to operate from a corrections philosophy.<sup>550</sup>

Mr Connock highlighted several similarities between the use of force incident in December 2017 and the earlier use of force incident that occurred in July 2016. According to Mr Connock, these similarities included that:

- de-escalation attempts appear to be limited
- the use of force was questionable
- there were no obvious immediate threats to the staff involved.<sup>551</sup>

Mr Connock questioned why the Department had not sought advice about whether the use of force in December 2017 amounted to an offence, considering that uses of force during the July 2016 incident had been referred to Tasmania Police.<sup>552</sup> Mr Connock said that it became apparent to him, when following up the December 2017 incident, that ‘an unwritten reason for not pursuing any formal action in this case was due to concerns about already low staff morale following the prosecution in 2016’.<sup>553</sup> Mr Connock characterised this rationale as ‘concerning’, considering that ‘the paramount consideration for the Department should be the safety and care of the vulnerable children in its care’.<sup>554</sup>

At the end of his report to the Secretary, Mr Connock suggested that the Department implements a formal process to ensure greater oversight of the use of force by Centre staff, namely that the Ombudsman’s office be notified of all future use of force incidents at Ashley Youth Detention Centre.<sup>555</sup>

## **6.8 Memorandum of Advice: Searches of children and young people in custody in custodial facilities in Tasmania, Commissioner for Children and Young People Tasmania (May 2019)**

In 2019, the Commissioner for Children and Young People provided a Memorandum of Advice to the Tasmanian Government about personal searches of young people in detention and the promotion of young people’s rights regarding these searches.<sup>556</sup> The memorandum was prepared amid media reports of routine strip searches of children in custodial environments, and in light of government data indicating 203 children were subject to an unclothed search at Ashley Youth Detention Centre between 1 June and 30 November 2018, with no contraband found.<sup>557</sup>

The Commissioner for Children and Young People considered legislation, policies and procedures applicable to children and young people in custody, and the National Royal Commission's recommendation that jurisdictions review their legislation, policies and procedures, to ensure best practices were in place for strip searches and other forms of physical contact between children and staff.<sup>558</sup> The Commissioner for Children and Young People noted that the Tasmanian Government had accepted this recommendation in principle.<sup>559</sup>

The Commissioner for Children and Young People concluded that the legislative framework appeared to allow routine strip searches of children in custodial environments.<sup>560</sup> She also observed that strip searching had the potential to distress, humiliate and traumatise children and young people.<sup>561</sup> The Commissioner for Children and Young People concluded that searches in custodial settings were sometimes necessary to ensure safety and stop contraband entering environments; however, given their potential to traumatise, the basis upon which such searches were to be conducted should be clear, consistent and contained in a single document.<sup>562</sup>

The Commissioner for Children and Young People made eight recommendations, including that the routine practice of strip searches cease, and that legislation be amended to require that searches of children only be conducted 'when reasonable, necessary and proportionate to a legitimate aim'.<sup>563</sup> Recommendations were also made to provide greater accountability for searches of children and young people in custody.<sup>564</sup>

The Tasmanian Government's response, dated 24 June 2020, indicated that the Government accepted all the recommendations and had reviewed operational procedures governing the searching of children in custodial settings.<sup>565</sup> We note that the *Youth Justice Amendment (Searches in Custody) Act 2022*, which amended the Youth Justice Act (as previously discussed), reflects the Commissioner for Children and Young People's recommendations. We discuss searches of young people at Ashley Youth Detention Centre in Chapters 11 and 12.

## 6.9 Inspection of Youth Custodial Services in Tasmania, 2018: Custody Inspection Report, Custodial Inspector Tasmania (August 2019)

In 2019, the Custodial Inspector reported findings following a 2018 inspection of Ashley Youth Detention Centre.<sup>566</sup> The report covered topics such as admission to custody, infrastructure, security, complaints, transport of young people in detention, use of force, use of isolation and emergency management.<sup>567</sup> The report raised concerns about reporting practices and procedures at Ashley Youth Detention Centre (which made it difficult to measure compliance and outcomes), the lack of a broad drug strategy, the use of force against young people in detention and the isolation of young people in detention.<sup>568</sup>



In responding to the report, the Department stated that in the 18 months since the inspection, ‘many of the issues identified in the report have already been addressed’.<sup>569</sup> The response indicated that a review of procedures for searches had occurred, and that the Government had committed \$7.28 million to upgrade Ashley Youth Detention Centre, after consultation with the Centre’s management, the Department, the Commissioner for Children and Young People, the Child Advocate and non-government organisations.<sup>570</sup> No specific reference was made to any consultation with current or former detainees of the Centre about the upgrade.

The Tasmanian Government expressed its general support for recommendations related to improved reporting and recording systems for incidents and risk assessments; improved complaints mechanisms; young people’s access to private phone calls; staff training, reporting and review of use of force and de-escalation techniques; and reviews of and improved reporting on the use of isolation.<sup>571</sup> The Government did not support two recommendations related to physical security at the Centre.<sup>572</sup> The Government’s response to another six recommendations in the report was redacted.<sup>573</sup>

## 6.10 Through the Fence and into Their Lives: Ashley Youth Detention Centre Trauma Informed Practice Framework, Discovery Phase, Janise Mitchell, Australian Childhood Foundation (April 2020)

In 2020, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, prepared a brief report summarising key learnings from consultations with internal and external stakeholders about developing a trauma-informed operating model for Ashley Youth Detention Centre.<sup>574</sup>

Consultations explored the strengths and challenges of the existing youth detention model, a needs analysis, and opportunities for ‘further development’ of a trauma-informed operating model.<sup>575</sup> Noting that previous efforts to develop trauma-informed models ultimately did not proceed, the report emphasised that ‘a trauma-informed practice framework and operating model will represent a significant paradigm shift for [Ashley Youth Detention Centre] and require a strong and sustained change-management approach’.<sup>576</sup> The report found that some staff lacked confidence in therapeutic approaches and were therefore fearful ‘of being critiqued negatively by managers’ if they used such approaches.<sup>577</sup>



The following key themes emerged from stakeholder consultations:

- There are many factors underlying young people’s offending behaviours, including poor mental health, trauma backgrounds and disabilities.<sup>578</sup>
- Awareness and understanding of the Ashley Youth Detention Centre Model of Care, which was designed in 2019 and sought to articulate a trauma-informed practice model, was very low, with some staff and stakeholders describing it in unfavourable terms.<sup>579</sup>
- Support for change from Centre staff was mixed, with a lack of support influenced by ineffective efforts to facilitate change in the past.<sup>580</sup>
- The culture and practice of Centre staff was characterised by confusion and a lack of safety, including a view that the approach to young people was more punitive than therapeutic.<sup>581</sup>
- The Centre’s operational environment was reactive, ad hoc and unsafe for staff and young people.<sup>582</sup>
- The culture at the Centre was ‘risk averse, focused on containment, and punitive in nature’.<sup>583</sup>
- Minimum qualifications for operational staff were not adequate, and staff with the ‘right attributes’ were needed.<sup>584</sup>
- The cultural needs of young people were often overlooked.<sup>585</sup>

The report identified that policies and procedures relevant to searches, the use of mechanical restraint, the use of physical force, personal identity/possessions, the use of isolation and cultural awareness guidelines should be reviewed as a matter of priority.<sup>586</sup>

The report suggested that the next steps towards establishing a bespoke, fit-for-purpose practice framework for youth detention included consultations with young people about what would be helpful for them.<sup>587</sup> The report did not nominate a timeline for this future work.

## 7 A system in crisis

Although few of the reports noted in this chapter directly considered child sexual abuse at Ashley Youth Detention Centre, they all identified problems affecting the safety of children and young people at the Centre. Broadly, these problems included:

- outdated policies and procedures
- insufficient staff understanding of, and adherence to, legislative and policy requirements relevant to the treatment of children and young people in detention
- a preference among management and staff for punishment rather than rehabilitation, including the use of force, strip searches and isolation techniques
- inappropriate facilities for young people in detention and their visitors
- lack of confidence among staff in management and governance arrangements
- resistance to change among staff and administrators
- limited access to support services for young people
- a lack of monitoring of some spaces
- a lack of access for young people to family, independent representatives or advocates
- poor incident reporting
- inappropriate records management
- inadequate complaints processes
- inadequate human resources support for staff, including oversight of sick leave, a reliance on casual staff and a high number of workers compensation claims.

A common theme in many of the previous reports and inquiries discussed in this chapter is the treatment of children and young people in detention. For example, the independent review of Ashley Youth Detention Centre by Ms Harker in 2015 found there was a culture of punitive responses to children and young people.<sup>588</sup> We note that, in describing a ‘punitive’ culture, the reports also raise concerns about the use of force, searches and isolation, a preference for securing compliance over de-escalation strategies and an ideological belief that a therapeutic approach is not a deterrent to recidivism. In our view, the term ‘punitive’ in this context minimises the true extent of the crisis in the treatment of children in Tasmanian youth detention. We consider it is an environment that is harmful to children and perversely increases, rather than decreases, a lack of safety for staff.

A recent Victorian parliamentary report examining youth detention in that state concluded that:

Punitive approaches to the management of youth justice services ... are unlikely to resolve the behavioural issues of detainees; instead, they serve to reinforce the sense of mistrust experienced by many children and young people in custody. Without a trauma-informed approach to the management of youth justice centres, at-risk children and young people will continue to face significant obstacles in their paths to recovery and rehabilitation, and staff in youth detention centres will continue to face significant difficulties in managing children and young people in their care.<sup>589</sup>

As an allied matter, the reports and inquiries show systemic challenges related to staffing at Ashley Youth Detention Centre that appear to contribute to the persistent problems in the culture and treatment of children detained there. These challenges appear to be well recognised, with more evidence provided to our Inquiry confirming they had existed for a long time and persist into the present. The Centre's isolated location appears to have been a significant contributor to the intractable nature of these systemic staffing challenges, which included:

- difficulties fully staffing the Centre due to challenges in attracting staff, high staff turnover and unplanned staff absences
- difficulties in resourcing, attracting, retaining and training an appropriately skilled and qualified workforce
- the long tenure of a core group of staff who resisted cultural change.

In conclusion, before our examination into institutional responses to child sexual abuse at Ashley Youth Detention Centre, it appeared that successive Tasmanian governments had been made aware of persistent systemic issues in the treatment of children detained at the Centre and had failed to achieve sufficient meaningful change to address those issues.

# Notes

## Introduction to Volume 5

- 1 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August, 2–3.
- 2 *Youth Justice Act 1997* ss 3, 83(3), 124(1).
- 3 Nina Papalia et al, 'Patterns of Maltreatment Co-occurrence in Incarcerated Youth in Australia' (2022) 37 *Journal of Interpersonal Violence* 7–8.
- 4 Statement of Elena Campbell, 4 July 2022, 2 [15]–3 [19]; Statement of James Ogloff, 22 August 2022, 18 [76]; Statement of Mark Morrissey, 9 August 2022, 4 [26]; *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 41; Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 93.
- 5 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 41.
- 6 Statement of Mark Morrissey, 9 August 2022, 19 [120].
- 7 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 49.
- 8 Refer to, for example, to Nick Clark, 'Ashley Boss Defends Action in Standoff', *The Mercury* (Hobart, 20 December 2002); Danny Rose, 'Ashley Called Training Ground for Risdon. Changes Urged for Youth Jail', *The Mercury* (Hobart, 5 April 2003) 7; Patrick Caruana, 'Detention Centre Where Teen Died May Close', *AAP General News Wire* (Sydney, 27 October 2010); Adam Holmes, 'Dozens Aged 13 and Under Strip-Searches in 2018', *The Examiner* (Launceston, 16 March 2019); Richard Baines, 'Ashley Youth Detention Standoff: Tasmanian Minister Demands Report into Staff Conduct: The Conduct of Staff During a Standoff at the Ashley Youth Detention Centre in Tasmania's North Prompts an Urgent Investigation and Calls for the Facility to be Closed', *ABC News* (Sydney, 16 August 2016).
- 9 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 10 Statement of Kathrine Morgan-Wicks, 24 May 2022, Annexure 2 (Department of Health, 'Timeline of Organisational Structure and Governance Arrangements', undated).
- 11 Statement of Kathrine Morgan-Wicks, 24 May 2022, Annexure 2 (Department of Health, 'Timeline of Organisational Structure and Governance Arrangements', undated); Department of Communities, *Annual Report 2018–2019* (Report, October 2019) 6
- 12 Statement of Michael Pervan, 27 July 2022, 52 [114].

## Chapter 10 – Background and context: Children in youth detention

- 13 Statement of Elena Campbell, 4 July 2022, 2–3 [15, 17]; Statement of Vincenzo Caltabiano, 13 July 2022, 9 [53].
- 14 Chris Cunneen, Barry Goldson and Sophie Russell, 'Human Rights and Youth Justice Reform in England and Wales: A Systematic Analysis' (2018) 18(4) *Criminology & Criminal Justice* 405.
- 15 Eileen Ahlin, 'Risk Factors of Sexual Assault and Victimization Among Youth in Custody' (2021) 36(3–4) *Journal of Interpersonal Violence* 2164.
- 16 Statement of Elena Campbell, 4 July 2022, 2–3 [15–17].
- 17 Statement of Elena Campbell, 4 July 2022, 3 [16].
- 18 Kath McFarlane, 'Care-Criminalisation: The Involvement of Children in Out-of-Home Care in the New South Wales Criminal Justice System' (2018) 51(3) *Australian & New Zealand Journal of Criminology* 412.
- 19 Statement of Robert White, 16 August 2022, 12 [44–45].
- 20 Statement of Elena Campbell, 4 July 2022, 5–7 [30–39]; Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 14.

- 21 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 41–43.
- 22 Eileen Ahlin, 'Risk Factors of Sexual Assault and Victimization Among Youth in Custody' (2021) 36(3–4) *Journal of Interpersonal Violence* 2164.
- 23 Eileen Ahlin, 'Forced Sexual Victimization among Youth in Custody: Do Risk Factors Vary by Gender and Perpetrator?' (2020) 100(2) *Prison Journal* 151, 158.
- 24 Eileen Ahlin, 'Forced Sexual Victimization Among Youth in Custody: Do Risk Factors Vary by Gender and Perpetrator?' (2020) 100(2) *Prison Journal* 151, 153, 160, 162, 164; Eileen Ahlin, 'Risk Factors of Sexual Assault and Victimization Among Youth in Custody' (2021) 36(3–4) *Journal of Interpersonal Violence* 2164, 2174, 2178.
- 25 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 39.
- 26 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 38.
- 27 Eileen Ahlin, 'Risk Factors of Sexual Assault and Victimization Among Youth in Custody' (2021) 36(3–4) *Journal of Interpersonal Violence* 2164.
- 28 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 43.
- 29 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 43; 90–91.
- 30 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023).
- 31 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 43.
- 32 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 52.
- 33 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 51.
- 34 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 54.
- 35 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 54.
- 36 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 59.
- 37 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 57.
- 38 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 60.
- 39 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 73.
- 40 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 67.
- 41 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 67.
- 42 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 15–18.

- 43 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 117.
- 44 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 118.
- 45 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 125.
- 46 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 129.
- 47 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 129.
- 48 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 132–135.
- 49 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 137.
- 50 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 136.
- 51 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 139 and 141.
- 52 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 9.
- 53 Department of Justice, *Tasmanian Government Fifth Annual Progress Report and Action Plan 2023* (Report, December 2022).
- 54 *United Nations Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).
- 55 *United Nations Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 37(b).
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# 11 Case studies: Children in youth detention

## Content warning

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

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

## 1 Introduction to case studies

In this chapter, we present seven case studies that examine different aspects of Ashley Youth Detention Centre.

The focus of our Commission of Inquiry is the State's response to known risks of child sexual abuse in institutions, including Ashley Youth Detention Centre. In this chapter, we also examine other forms of mistreatment of detainees (for example, physical abuse or degrading treatment) that we consider relevant to understanding the context in which child sexual abuse occurs. We also note that children's vulnerability to child sexual abuse is heightened in contexts where other abuses and rights violations are prevalent.<sup>1</sup>

In Case study 1, we describe the nature and extent of abuse at the Centre, including the evidence we received from several current and former detainees, as well as allegations



made through redress schemes and civil claims. This evidence is harrowing, describing abuses that are callous, cruel and degrading. Children and young people's powerlessness in the face of such ingrained abuse and mistreatment is palpable and devastating. The consistency of themes across all these accounts, despite coming from multiple sources, is striking and includes:

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

While we did not test the truth of individual accounts, we gave particular weight to the consistency across the accounts of victim-survivors whom we heard from directly and those that we read in claims under the Abuse in State Care Program and the National Redress Scheme. In the accounts of different people detained at the Centre over different periods, and the information coming from direct accounts, critical incident reports and state and Commonwealth redress schemes, we saw a striking consistency (and enough variability) to the places and ways abuses occurred, the people who were allegedly responsible and the patterns and kinds of sexually abusive behaviours.

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

In Case study 2, we examine the extent of harmful sexual behaviours at the Centre and responses to such behaviour. We include some accounts of former detainees who describe sexual harm by other detainees at the Centre and how this was often ignored by staff. We also heard allegations that staff sometimes actively used the harmful behaviours, including harmful sexual behaviours, of some detainees to control or frighten other detainees. We make findings in this case study about failures to respond appropriately to the risks of harmful sexual behaviours, which are listed in Section 9 and explained further in the case studies. In particular, we find that Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these harms.

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

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

When the isolation of young people at Ashley Youth Detention Centre is unauthorised, unregulated and unreported, or there is excessive use of force, the risk of and opportunities for the physical and sexual abuse of young people increases. Such belittling and dehumanising practices also reduce the likelihood of children and young people making disclosures of child sexual abuse because their sense of what is right and wrong, trust in adults at the Centre and self-worth have been undermined.

Case studies 5 and 6 describe how complaints about the safety and treatment of detainees have been managed—including complaints by a staff member called Alysha (a pseudonym) and a detainee called Max (a pseudonym).<sup>2</sup> We make findings about the State, the Department and the Centre’s response to these complaints, and identify systemic problems in these responses.

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

## 1.1 How to read our case studies and examples

Many of our case studies are closely related and benefit from being read together. While findings may sit within a particular case study, in some instances those findings

also draw on evidence described in others. For example, our finding that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse in Case study 1, also draws on the evidence we examined in Case studies 3, 4 and 7. Case studies 3 and 4 expand on some of the common themes we heard in Case study 1 about alleged abuse and mistreatment connected to isolation practices and the use of force, including previous reports and reviews. Case study 7 discusses a range of documentation outlining allegations of abuse that were in addition to the accounts we heard from people who had been detainees at the Centre or their families.

Case studies 5 and 6 describe responses to complaints (in one instance from a detainee and, in the other, a staff member). Taken together, our seven case studies have informed our recommendations in Chapter 12.

## 1.2 Key witnesses and sources of information

Throughout the case studies in this chapter, we refer to several people who held senior departmental roles. In addition to our requests for information from the Tasmanian Government, we also requested statements and information from people who had a role in the response or may have had access to relevant information. Some of these people were no longer in the Department, which limited their access to information. Some joined the Department after the events into which we inquired and gave us information based on what was available to them, but in relation to matters with which they had no personal involvement.

Here, as a reference point, we summarise the key role-holders and witnesses who provided information in relation to our case studies:

- Michael Pervan held the role of Secretary in the then Department of Health and Human Services and Department of Communities for the period from around October 2015 until July 2022 (other than between May 2018 and September 2019 during the split of the Department of Communities from the Department of Health and Human Services).<sup>3</sup> The functions previously held by Secretary Pervan have since moved to sit within the Department for Education, Children and Young People, overseen by Secretary Timothy Bullard.<sup>4</sup> Prior to his formal appointment, Secretary Pervan had been Acting Secretary of the Department of Health and Human Services from March 2014 until his permanent appointment in October 2015.<sup>5</sup>
- Ginna Webster has been Secretary of the Department of Justice since September 2019, and was previously the Secretary of the Department of Communities from May 2018 to September 2019.<sup>6</sup> Prior to May 2018, Secretary Webster held the role of Deputy Secretary, Children and Youth Services in the then Department of Health and Human Services.<sup>7</sup>

- Mandy Clarke held the role of Deputy Secretary, Children, Youth and Families, which had portfolio responsibility for Ashley Youth Detention Centre, among other things.<sup>8</sup> Ms Clarke reported to then Secretary Pervan.<sup>9</sup> Ms Clarke was Deputy Secretary from 11 September 2019 to 11 February 2022, with her last working day being 21 January 2022.<sup>10</sup>
- Kathy Baker held the role of Executive Director, Capability and Resources between July 2018 and September 2021. That role was subsequently reclassified Deputy Secretary, Corporate Services, and was held by Ms Baker between September 2021 and 30 June 2022, although she was seconded to the Department of Health between 10 March 2020 and 5 June 2020.<sup>11</sup> She reported directly to then Secretary Webster between July 2018 and September 2019 and subsequently to then Secretary Pervan (except during her secondment).<sup>12</sup> The role had responsibilities for corporate areas including People and Culture, Legislation and Legal Services, and Governance Risk and Performance (as they were then known)<sup>13,14</sup>
- Jacqueline Allen commenced the role of Acting Assistant Director, Safety, Wellbeing & Industrial Relations, which was part of the People and Culture Division, in July 2020.<sup>15</sup> She reported to the then Director of People and Culture.<sup>16</sup> At the time she gave evidence at our public hearings in August 2022, Ms Allen was the Acting Executive Director, People and Culture (but had left that role by December 2022). We note that, despite her short tenure at the Department, Ms Allen provided us with a large amount of documentary evidence in response to our requests for information. This included in relation to events that occurred before her commencement at the Department and with which she was not involved, and often where we had not been provided with those documents in response to other requests. We were grateful for her efforts in this regard.
- Greg Brown held the role of Director, Strategic Youth Services, within the Department between December 2017 and October 2019.<sup>17</sup>
- Pamela Honan has held the role of Director, Strategic Youth Services (also titled Director, Youth and Family Violence Services) within the Department since 28 October 2019.<sup>18</sup> The title of this role has changed over time but we understand that Ms Honan has had responsibility for Ashley Youth Detention Centre since she commenced employment with the Department.<sup>19</sup> Ms Honan reported to Ms Clarke.<sup>20</sup>
- Patrick Ryan was Manager, Custodial Youth Justice ('Centre Manager') at Ashley Youth Detention Centre from January 2017 until March 2020. Mr Ryan reported to Mr Brown and Ms Honan.<sup>21</sup>
- In March 2020, Stuart Watson was appointed Acting Centre Manager (from his role as Assistant Manager, which he had held since January 2020).<sup>22</sup> Mr Watson was appointed as the ongoing Centre Manager in March 2021.<sup>23</sup> Mr Watson reported to Ms Honan.<sup>24</sup>

# Case study 1: The nature and extent of abuse in Ashley Youth Detention Centre

## 1 Introduction

In this case study, we find that children and young people at Ashley Youth Detention Centre have experienced systematic harm and abuse for decades.

This finding is based on several sources—described in this case study—as well as the evidence outlined across the subsequent case studies.

This case study contains a series of concerning allegations against Ashley Youth Detention Centre staff. We acknowledge that there have been, and are, staff at Ashley Youth Detention Centre who have tried to do their jobs lawfully and appropriately. References to problematic practices by ‘staff’ in this case study are not intended as a reference to all staff at Ashley Youth Detention Centre, unless explicitly stated in a specific context.

While we focus primarily on allegations of abuse by staff, we also heard of allegations of abuse by other children and young people, which were sometimes said to have occurred with the knowledge or endorsement of staff.<sup>25</sup> We discuss this type of abuse (harmful sexual behaviours) in more detail in Case study 2. Understanding the extent and nature of abuse at Ashley Youth Detention Centre was essential to informing our recommendations. It is also important that any agency responding to allegations of abuse at the Centre does so with knowledge of this history of abuse.

On the evidence that was available to us, it was apparent that sexual abuse at Ashley Youth Detention Centre occurred alongside physical and verbal abuse. The sexual abuse perpetrated by some staff appears to have been motivated by a desire for sexual gratification. For other staff, the sexual abuse appears to have been one of many ways they asserted their dominance over, and otherwise degraded, detainees at the Centre, and may not have been sexually motivated.

In this case study, we outline sources of information about sexual and other abuse at Ashley Youth Detention Centre. Data from these sources tells us that numerous allegations of abuse, including of sexual abuse, at the Centre and its predecessor, Ashley Home for Boys, have been made through formal channels since 2003, when the Abuse in State Care Program was established.

We then summarise several of the many accounts of abuse that we received from victim-survivors of Ashley Youth Detention Centre, or their family members, during our Commission of Inquiry. In total, 11 victim-survivors and family members gave us permission to report their experiences, albeit anonymously.

It was not possible for our Commission of Inquiry to test the veracity of all the allegations outlined in victim-survivors' accounts. However, we were struck by the common accounts of sexual, physical and other abuse by staff at the Centre, or older detainees, or both. Themes included the misuse of strip searches by Centre staff, how and where the abuse was perpetrated, and the absence or failure of effective reporting mechanisms when children and young people sought help to stop the abuse. While we do not make findings in relation to any individual allegation, we note the similarities across accounts.

The accounts of victim-survivors documented in this case study allege sexual and other abuse at Ashley Youth Detention Centre from the early 2000s to as recently as the early 2020s. At least some of the staff who were alleged to have perpetrated this abuse had worked at the Centre for many years at the time complaints were first made against them. They continued to work at the Centre for many more years due to the Department's slow and uncoordinated response to redress claims and allegations of abuse (we discuss this in Case study 7).

Later in this case study and in Case study 7, we discuss the Department's realisation in 2020 that many staff members against whom allegations of abuse had been made were still working at Ashley Youth Detention Centre.

We have included these accounts because we consider it is necessary that the Tasmanian Government understands the experiences of young people in detention, as well as the culture of sexual and other forms of abuse, denigration and human rights violations of children and young people that has persisted at Ashley Youth Detention Centre, to respond effectively to allegations of abuse in youth detention.

## 2 Data about child sexual abuse at Ashley Youth Detention Centre

The Department has received allegations of child sexual abuse at Ashley Youth Detention Centre, from multiple sources, over a long period. In this section, we outline the avenues through which the Department has received these allegations. We note various inconsistencies about the extent of abuse between the data collected by different bodies and for different purposes. In Chapter 12, we emphasise the importance of collecting and comparing data about the sexual and other forms of abuse of children and young people under the care of the State and recommend an audit of allegations of abuse (refer to Recommendation 12.5).

## 2.1 Response to our notice to produce

To understand the nature and extent of child sexual abuse at Ashley Youth Detention Centre, we issued a notice to produce information, which asked the Department to:

Produce any document which summarises—or if no such document exists, prepare a document which describes—the following information for ... Ashley Youth Detention Centre in relation to any allegations or incidents of child sexual abuse (including allegations or incidents of misconduct against children which may constitute child sexual abuse) in Institutional Contexts for each year of the Relevant Period [this is defined as 1 January 2000 to the date of the notice]:

- a. the number of allegations or incidents
- b. the dates of those allegations or incidents
- c. the nature of those allegations or incidents
- d. any investigation of those allegations or incidents
- e. any reporting or referral of those allegations or incidents to a law enforcement or regulatory agency, or Child Safety Services, or
- f. any action or outcome as a result of those investigations, allegations or incidents.<sup>26</sup>

The Department told us it collected child sexual abuse allegations made by former detainees from a range of sources including claims made through the Abuse in State Care Program, civil litigation claims and the National Redress Scheme to provide us with a number of documents.<sup>27</sup> We continued to receive information (often in the form of spreadsheets) over the course of our Inquiry.

There were significant discrepancies across the data we received about sexual abuse incidents at Ashley Youth Detention Centre. Barriers to us understanding the scope and scale of abuses included the following:

- *Incompatible documentation.* We received multiple and differing documents and spreadsheets recording varying numbers of incidents, which were difficult to reconcile across different sources and agencies, particularly where dates were vague or within a broad range. Also, different aspects of an incident were described or reported to different audiences and in some instances, alleged abusers and victim-survivors were unnamed.
- *Very limited details relating to some incidents.* We accept that sometimes this was unavoidable due to the limited nature of information the Department received (for example, through a National Redress Scheme claim) but, at times, suggested incomplete departmental record keeping.



- *Differences in how data is segmented and reported.* For example, the various public reports relating to the Abuse in State Care Program segmented data differently, sometimes breaking down the number of claims by institution, allowing us to understand specifically how many related to Ashley Youth Detention Centre or Ashley Home for Boys, and other times generalising to institution type ('government institution'), which made this impossible.

We consider some discrepancies may have arisen in the number and nature of incidents that the Department reported to us because of the following:

- *Confusion around what fell within the 'Relevant Period'.* There was uncertainty about whether our request related to incidents that had occurred within that period or were reported or otherwise made known to the Department within that period (but may have occurred before 2000). In most documents, the Department has appeared to have adopted the former approach in only reporting incidents that fall within the relevant period (noting sometimes abuse may have predated but overlapped with this period—for example, 1998–2002).
- *The Department not adopting a consistent definition of what constitutes child sexual abuse.* For example, the Department sometimes did not include incidents relating to harmful sexual behaviours between detainees or complaints about a staff member applying cream to a detainee's genitals. At other times, the Department did include such incidents.

We consider that the discrepancies were more likely to lead to an underreporting of incidents to us.

We invested significant effort to accurately reflect the information we received, but it has been difficult—indeed impossible—for us to entirely assure ourselves of the completeness and accuracy of some of the figures and information we received. Often, witnesses could not help us clarify discrepancies or broaden our understanding of some of these incidents.

These challenges mean there are internal inconsistencies in some of the information we present. In the interests of the reader, we have at times prioritised clarity ahead of providing detailed explanations or clarifications of inconsistencies and limitations in the documentation we received, particularly where we could find no such explanation.

With these limitations in mind, the next section outlines the key sources of information relating to reports of child sexual abuse at Ashley Youth Detention Centre.

## 2.2 The Abuse in State Care Program

In July 2003, the Tasmanian Government announced a review of claims of abuse, including sexual abuse, by people who had been in state care as children, including in youth detention and in out of home care. The Government ran the Claims of Abuse in State Care Program ('Abuse in State Care Program') over four rounds between 2003 and 2013, resulting in 2,414 claims and 1,848 ex gratia payments (voluntary payments made as a gesture of goodwill without any legal obligation). These payments totalled to \$54.8 million.<sup>28</sup> To be eligible to make a claim, a person had to be aged 18 or older on 11 July 2003 and not have been a claimant in a previous round of the Abuse in State Care Program.<sup>29</sup> The eligibility criteria were set at the beginning of the first round and remained the same (including in relation to the age requirement) through all rounds of the program.<sup>30</sup>

The Department of Communities' predecessor, the Department of Health and Human Services, was involved in each round of the program, with the first two rounds delivered as a joint undertaking with the Office of the Ombudsman and the Department of Health and Human Services. The third round was administered by the Department of Premier and Cabinet in partnership with the Department of Health and Human Services. The Department of Health and Human Services was solely responsible for administering the final round of the program.<sup>31</sup>

Many allegations of abuse at Ashley Youth Detention Centre (and Ashley Home for Boys) were raised in each round of the program. New rounds of the Abuse in State Care Program were initiated in response to new claimants coming forward.<sup>32</sup>

According to reports published on the various rounds of the Abuse in State Care Program (which varied in the level and type of information they provided about claims):

- During the first round, which ran from 2003 to 2004, 32 people made claims relating to abuse that occurred at Ashley Home for Boys.<sup>33</sup> The report described, in general terms, that most of these claims related to 'sustained physical and emotional abuse', with allegations of sexual abuse described as 'less common' in boys' homes (including Ashley Home for Boys).<sup>34</sup>
- In the second round, which ran from 2005 to 2006, 117 people came forward claiming abuse that occurred at Ashley Home for Boys.<sup>35</sup> We are unclear what type of abuse these claims relate to but note that across all eligible claims (423) made in this period, 189 (or 45 per cent) included sexual abuse.<sup>36</sup>
- There were 995 claims (in total) made in the third round, which ran from 2007 to 2010. We have not been able to identify the number of claims that were made relating to Ashley Home for Boys or Ashley Youth Detention Centre because a detailed report on this third round of claims was not available (we drew the overall 995 figure from the report of the fourth round of claims).<sup>37</sup>

- The fourth round of the program, which ran from 2011 to 2013, resulted in 172 claims against Ashley Home for Boys and Ashley Youth Detention Centre.<sup>38</sup> We are unsure what proportion of these claims relate to sexual abuse but note that, of the 199 claims of sexual abuse made during that round, nearly 50 per cent were made by claimants who were placed in an institution (including Ashley Youth Detention Centre).<sup>39</sup>
- The number of claims listed in the reports on rounds 1, 2 and 4 of the Abuse in State Care Program indicate that, in these three rounds alone, 321 claims of abuse were made in relation to Ashley Youth Detention Centre or Ashley Home for Boys.

The Department provided us with a spreadsheet listing allegations or incidents of child sexual abuse since 2000. The spreadsheet showed that 18 claims of child sexual abuse were made against Ashley Youth Detention Centre staff through the Abuse in State Care Program (some of which included multiple allegations).<sup>40</sup> It also indicated that the Department of Health and Human Services began to receive these claims in 2008 and that the period of abuse to which these claims related spanned 1995 to 2013.<sup>41</sup> Not all claims received by the Department of Health and Human Services were eligible for redress, due to not meeting the age requirement or for other reasons.<sup>42</sup>

The discrepancy between the Department's spreadsheet and the data in the Abuse in State Care Program reports is likely to be partially attributed to the scope of our request to the Department, which did not include a request for allegations relating to Ashley Home for Boys, which closed in 2000. The discrepancy may also be partly due to the Abuse in State Care Program reports referring to physical and sexual abuse, as well as abuse alleged to have been perpetrated by other children and young people (which were not captured in the Department's spreadsheet). Discrepancies may also be due to different interpretations of sexual abuse.

## 2.3 Other government data

The Department provided us with several other documents indicating that many claims of child sexual abuse were made against staff at Ashley Youth Detention Centre and Ashley Home for Boys through the Abuse in State Care Program:

- A spreadsheet provided by the Child Abuse Royal Commission Response Unit in the Department of Justice to the Department of Communities on 19 September 2020 indicated there were 127 claims of child sexual abuse made against named staff members through the Abuse in State Care Program (some of whom were named on multiple occasions).<sup>43</sup>

- The Department of Justice also provided our Commission of Inquiry with a different table of data relating to the Abuse in State Care Program that was ‘extracted from a manual review of hard copy files during the Royal Commission into Institutional Responses to Child Sexual Abuse’.<sup>44</sup> This information indicated that:
  - Claims of sexual abuse were made against Ashley Youth Detention Centre or Ashley Home for Boys staff through the Abuse in State Care Program as early as 2003, although it is unclear when the Department received these earlier claims given there were different administrators of the scheme (we consider it would have been during the period of the first phase of the scheme—2003 to 2004).<sup>45</sup>
  - Based on our review of the listed claims in the Abuse in State Care Program, at least 95 of the accepted claims involved named staff, and at least 44 involved unnamed staff, at Ashley Youth Detention Centre or Ashley Home for Boys.<sup>46</sup> Several staff had multiple claims made against them. We note that the number of claims of child sexual abuse against staff members is likely higher because there were claims that did not specifically refer to, or name, staff members and, therefore, have not been included in our analysis because they may have related to harmful sexual behaviours.
  - The period of abuse spanned much longer, dating back to the 1940s.

As we discuss later in this case study, staffing at the Centre had been relatively stable, with many staff moving from Ashley Home for Boys to Ashley Youth Detention Centre in 2000 and continuing to work there through the 2000s.

We note that the Department of Communities’ and the Department of Justice’s spreadsheets described above provide summaries of the claims made under the Abuse in State Care Program.<sup>47</sup> It is clear from these documents that there is a commonality in the types of sexual abuse claims against staff at Ashley Home for Boys and Ashley Youth Detention Centre. The claims include allegations of rape, abuse during strip searches, abuse through applying scabies cream on detainees’ genitals, detainees being watched in the shower, the use of bribes and threats to force detainees to engage in sexual acts, forcing detainees to engage in sexual acts with each other, and sexual abuse occurring in the Centre’s ‘secure unit’ and when detainees were taken off site.<sup>48</sup> As we describe, these types of abuse were also raised through other avenues over different periods and correlate with the accounts provided to us by victim-survivors.

## 2.4 The Abuse in State Care Support Service

When the Abuse in State Care Program wound up in 2013, it was replaced by the Abuse in State Care Support Service. The Abuse in State Care Support Service was set up to provide financial support to people who experienced abuse, including sexual abuse, in state care when they were children.

As with the Abuse in State Care Program, the Abuse in State Care Support Service is available to people who had previously been detained at Ashley Youth Detention Centre, as well as those who were in other forms of state care.<sup>49</sup> The process for accessing financial support under the service involves the applicant being interviewed by the Department and having a ‘discussion with the Applicant about counselling and other supports’.<sup>50</sup> Up to \$2,500 is available for successful claimants to pay for goods and services related (but not limited) to education, employment, counselling, personal development, family connection and medical and dental services.<sup>51</sup>

Michael Pervan, former Secretary, Department of Communities, told us in a statement dated 14 June 2022 that 185 people had made applications or requested information since the service began in 2013, of which 89 applications alleged sexual abuse.<sup>52</sup> We understand that this relates to claims in relation to all forms of state care. Secretary Pervan could not provide us with the number of applications that had been approved, but said that of those who received financial support through the service, fewer than 20 applicants received less than \$2,000.<sup>53</sup>

Information provided to us by the Department of Communities in response to our notice to produce indicated that, as of 20 July 2021, 26 claims had been made through the Abuse in State Care Support Service involving allegations of sexual abuse at Ashley Youth Detention Centre (or its predecessor, the Ashley Home for Boys).<sup>54</sup> Most of the allegations related to conduct by Ashley Youth Detention Centre staff.<sup>55</sup> The period of abuse spans from 1995 to 2012.<sup>56</sup>

The claims raised through the Abuse in State Care Support Service include similar allegations against staff to those raised through other avenues and in victim-survivors’ accounts. The allegations again included abuse during regular and random strip searches; abuse by applying cream, powder and lotion to detainees’ genitals; detainees being watched in the shower; using bribes and threats to force detainees to engage in sexual acts; forcing detainees to engage in sexual acts with each other and in the presence of others including Centre staff; and sexual abuse occurring in the Centre’s ‘secure unit’ and when detainees were taken off site.<sup>57</sup>

## 2.5 The National Redress Scheme

As discussed in Chapter 17, the National Redress Scheme was created in response to National Royal Commission recommendations. The purpose of the Scheme is to hold institutions accountable for child sexual abuse and to help people who have experienced institutional child sexual abuse to access counselling, a direct personal response and a redress payment. The National Redress Scheme started on 1 July 2018. It will run for 10 years and is only available to people who were born before 30 June 2010 and whose abuse occurred before 1 July 2018.<sup>58</sup>

The National Redress Scheme is administered by the Australian Government. Tasmania's Child Abuse Royal Commission Response Unit (which sits within the Department of Justice) responds to requests for information about the Scheme, with the assistance of other agencies.<sup>59</sup> On receiving a request for information relevant to Ashley Youth Detention Centre, the role of the Department for Education, Children and Young People is to undertake a desktop investigation and provide a summary of material relevant to the National Redress Scheme claim to the Department of Justice.<sup>60</sup> We outline this process in more detail in Case study 7.

As of 20 July 2021, the Department had received 49 National Redress Scheme claims for allegations of child sexual abuse at Ashley Youth Detention Centre (some of which contained multiple allegations).<sup>61</sup> In total, these claims included 53 allegations against Ashley Youth Detention Centre staff members (including youth workers, security guards and contractors), with the alleged period of abuse spanning from 1995 to 2012.<sup>62</sup> Allegations were also raised against other detainees.<sup>63</sup>

Of the 49 National Redress Scheme claims the Department received, 10 claims were made in 2019, 14 claims were made in 2020, 24 claims were made in 2021 and it is unclear when the remaining claim was made.<sup>64</sup>

Secretary Pervan told us that, from 20 July 2021 until 27 May 2022, there were another 49 claims made under the National Redress Scheme (and five civil claims) for incidents dating between 1997 and 2016.<sup>65</sup> Other information in relation to these additional claims suggests that there were 48 National Redress Scheme claims and six civil claims relating to conduct alleged to have occurred over the period 1997 to 2019.<sup>66</sup>

Again, the allegations the Department received indicate a commonality in the methods of abuse allegedly perpetrated by Ashley Youth Detention Centre staff, including abuse during strip searches; abuse through applying products to detainees' bodies and genitals; detainees being watched in the shower; rape; using bribes and threats to force detainees to engage in sexual acts; forcing detainees to engage in sexual acts with each other and in the presence of others including Centre staff; and sexual abuse occurring in the Centre's 'secure unit' and when detainees were taken off site.<sup>67</sup>

## 2.6 Civil claims

As discussed in Chapter 17, the Tasmanian Government has made several legislative amendments in response to recommendations of the National Royal Commission, which pave the way for more civil claims to be issued against institutions that may be vicariously liable for the conduct of their staff, or liable for failing to protect a child from abuse.

In response to a notice to produce, the Department provided information to our Inquiry about civil claims that relate to allegations of child sexual abuse at Ashley Youth Detention Centre for the period 2000 to 20 July 2021.<sup>68</sup> Secretary Pervan provided further information for the period 20 July 2021 to 27 May 2022.<sup>69</sup> The data indicates that:

- In 2019, one civil claim was issued in relation to Ashley Youth Detention Centre.<sup>70</sup>
- In 2020, four civil claims were issued in relation to Ashley Youth Detention Centre.<sup>71</sup>
- In 2021, one civil claim was issued in relation to Ashley Youth Detention Centre.<sup>72</sup>
- From 20 July 2021 to 27 May 2022, six civil claims were issued in relation to Ashley Youth Detention Centre.<sup>73</sup>

The dates of the incidents raised in these claims up to July 2021 span 1998 to 2010.<sup>74</sup> The additional civil claims the Department received between 20 July 2021 and 27 May 2022 relate to conduct alleged to have occurred between 2002 and 2008.<sup>75</sup> Most of these claims include allegations against staff members, and the allegations involve similar methods of abuse identified in our discussion of the redress schemes above.<sup>76</sup> The allegations in these civil claims include rape, digital penetration, being forced to engage in sexual acts with other detainees and Centre staff (sometimes in the presence of other Centre staff), being photographed while performing sexual acts, using physical abuse and threats, being placed in settings where sexual abuse by other detainees took place, sexual abuse by staff while off site, and the application of products to bodies, including genitals.<sup>77</sup>

We also received evidence that suggests many more civil claims have been issued in relation to physical abuse at Ashley Youth Detention Centre. A briefing for the Minister for Children and Youth that Secretary Pervan cleared on 4 November 2021 states:

As of 18 October 2021, 42 civil claims [have been made] in relation to physical and/or sexual abuse that involve the Department (or its predecessor). Court proceedings have commenced for 12 of these matters.<sup>78</sup>

Also, on 11 August 2022, a class action was commenced in the Supreme Court of Tasmania on behalf of more than 100 former Ashley Youth Detention Centre detainees, with more claimants being added at the time of writing.<sup>79</sup> The claim of the lead plaintiffs is that the former detainees named as part of the class action suffered serious injuries due to systemic negligence in the management of Ashley Youth Detention Centre over the period from 1961 to 2019. Allegations include that staff:



- performed degrading strip searches
- forcibly applied scabies treatments that caused burns to detainees' bodies, including their genitals
- failed to provide appropriate medical treatment
- used isolation and beatings as punishment.<sup>80</sup>

Lawyers acting for the plaintiffs in the class action, Angela Sdrinis Legal, told us that they act for more than 150 clients who allege abuse at Ashley Youth Detention Centre and Ashley Home for Boys, some of whom are not part of the class action.<sup>81</sup> In a submission to our Commission of Inquiry, Angela Sdrinis Legal told us that these clients' complaints relate to:

- sexual abuse spanning more than 40 years, with many of the same abusers (detainees or employees) committing repeated abuse against numerous children throughout their time at Ashley Youth Detention Centre<sup>82</sup>
- an extensive range of abuse, including rape (54 clients), grooming (11 clients), oral rape (nine clients), object rape (10 clients), forced sexual acts between children (two clients) and contact abuse<sup>83</sup>
- many instances of physical and mental abuse that accompanied the sexual abuse, such as extended periods of isolation and regular beatings<sup>84</sup>
- staff manipulating children into performing sexual acts on each other or on guards, sometimes through threats of physical violence or denial of certain privileges such as personal visits, or to avoid isolation<sup>85</sup>
- staff encouraging children to take part in abuse through perceived rewards or treats, such as cigarettes.<sup>86</sup>

## 2.7 Direct reports to the Department

As well as civil claims, and claims raised through the redress schemes, the Department also receives complaints and allegations directly from young people who are (or were) detained at Ashley Youth Detention Centre, staff and others with knowledge of alleged misconduct at the Centre. For example, the Department told us that it had received complaints from the then Tasmanian Greens Leader Cassy O'Connor MP in December 2020 and a member of the public in August 2020, as well as referrals from Crime Stoppers reports.<sup>87</sup> The Department may also be alerted to complaints through reports by the Ombudsman, Custodial Inspector and Commissioner for Children and Young People.

In response to our notice to produce, the Department told us the following about complaints (in addition to allegations raised through civil claims and redress schemes) of child sexual abuse by Ashley Youth Detention Centre staff during the period 1 January 2000 to 20 July 2021:

- Several complaints about incidents alleged to have occurred between 2007 and 2016 were physically stored in a filing cabinet at Ashley Youth Detention Centre. Of the approximately 200 complaints the Department reviewed:
  - 10 related to allegations or incidents of child sexual abuse<sup>88</sup>
  - of these 10 complaints, at least six of the allegations were against staff members<sup>89</sup>
  - the allegations include staff members inappropriately touching detainees (including during strip searches), making sexual comments and walking in on a detainee while they were in the shower.<sup>90</sup>
- Another complaint was made to the Department’s Client Liaison Officer in January 2021. The detainee alleged that during the period from 2015 to 2016 they were forcibly strip searched and, on a separate occasion, assaulted.<sup>91</sup>

It is not clear to us if any of these complaints relate to staff still working at the Centre.

We also discuss in Case studies 5 and 7 a report in 2020 made by staff member Alysha (a pseudonym) about multiple concerns about the Centre, including allegations of child sexual abuse and staff management of harmful sexual behaviours.<sup>92</sup>

## 2.8 Observations across data

It is difficult to put a specific number to the allegations of child sexual abuse at Ashley Youth Detention Centre received by the Department. Nevertheless, there have been hundreds of allegations over the years.

Based on the material discussed above, we consider it is likely the Department of Health and Human Services knew of serious allegations of abuse against current staff working at Ashley Youth Detention Centre from at least 2006 when the second phase of the Abuse in State Care Program ended, if not from 2003. By 2006, there were 149 claims involving Ashley Youth Detention Centre or Ashley Home for Boys. As discussed below, staff at the Centre had been relatively stable and many staff moved from Ashley Home for Boys to Ashley Youth Detention Centre in 2000. We discuss the Department’s knowledge of allegations of abuse through this program in Case study 7.

## 3 First-hand accounts of abuse at Ashley Youth Detention Centre

In this section, we summarise the accounts of nine victim-survivors of Ashley Youth Detention Centre and two family members of victim-survivors.

As noted earlier, it was not possible for our Commission of Inquiry to test the veracity of all allegations of abuse, but we identified many common themes in the accounts we heard. We have included these accounts so the Tasmanian Government and the Tasmanian community can get a better sense of the extent and nature of the abuse that has occurred at Ashley Youth Detention Centre as safeguarding reforms are considered and implemented.

The accounts below speak to the circumstances of victim-survivors' residency at the Centre, the alleged abuse that victim-survivors suffered, their attempts and attempts by their family members to report the abuse, the impact the alleged abuse continues to have on them, and the changes they would like to see so other children and young people in detention do not have to experience similar trauma.

Most names used in the following case examples are pseudonyms. The case examples present the accounts of victim-survivors or those of their family members.

### 3.1 Case example: Ben

#### 3.1.1 Before Ashley Youth Detention Centre

Ben's (a pseudonym) early life was unsettled.<sup>93</sup> His parents separated when he was very young and his father died before Ben was 10 years old.<sup>94</sup> Ben moved in with his mother's new family and he began misbehaving, skipping school, stealing and using drugs.<sup>95</sup> He then ran away from home and was exposed to more serious drugs and crime.<sup>96</sup>

#### 3.1.2 Admissions to Ashley Youth Detention Centre

Ben was 11 years old when he was first detained at Ashley Youth Detention Centre in the early 2000s.<sup>97</sup> He was charged with property offences and he refused to be bailed to his mother's address.<sup>98</sup> With no other address for bail, Ben was sent to Ashley Youth Detention Centre on remand.<sup>99</sup>

Ben described to us his experience of being admitted to the Centre. He recalled that after a three-day period of isolation and observation:

I was made to strip naked and face a wall with my hands above my head, legs apart. One of these men [a staff member] started to roughly smother some lice cream of some kind up my bum crack all over my bum between my legs and all

over my genitals and surrounding area, as another one of them done the same to my underarms and my head. I was made to stand there for 5–10 minutes it was really painful and burning me. I complained but was told I'd have it left on there longer if I didn't shut up. Upon the completion of my intake assessment I was taken to my cell/room where I would stay for several long very traumatic weeks.<sup>100</sup>

Ben spent the rest of his childhood, until the late 2000s, in and out of the Centre.<sup>101</sup> From his first admission to when he was aged 18, the longest period Ben spent outside detention was about five months.<sup>102</sup> Ben recalled that he spent most of his time at the Centre on remand.<sup>103</sup> He explained that, most of the time, he was remanded for crimes for which he was eventually acquitted.<sup>104</sup>

### 3.1.3 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

Ben said that during his first admission he 'witnessed the most violence [he had] ever seen in [his] life'.<sup>105</sup> Ben told us that his first experience of sexual abuse at the Centre happened immediately after his first admission.<sup>106</sup> Ben recalled he was placed in a unit with six much older boys, four of whom physically and sexually abused him.<sup>107</sup> Ben said that after a few weeks, he was moved to a unit with other 'young and vulnerable detainees'.<sup>108</sup>

Ben said that he was physically and sexually abused by older boys at the Centre several times during his admissions.<sup>109</sup> He recalled that this abuse occurred 'every day' during his first admission.<sup>110</sup> Ben said that younger detainees were vulnerable to older male detainees, some of whom were 21 years of age.<sup>111</sup>

Ben told us that he was hospitalised on several occasions during his time at the Centre, including for an injury suffered during an episode of violent sexual abuse by an older boy.<sup>112</sup> He said that some members of staff at the Centre would, on occasion, incite and reward young people for abusing or humiliating other (usually younger or smaller) detainees.<sup>113</sup> Ben told us that young people were encouraged by staff to 'smack their mates' and were offered cigarettes as rewards.<sup>114</sup>

Ben said that he soon learned that the abuse at the hands of older boys 'would be nothing compared to what several of the officers would come to do to me'.<sup>115</sup>

### 3.1.4 Allegations of abuse by Ashley Youth Detention Centre staff

Ben told us that he and other young people were physically and sexually abused by staff on numerous occasions. He said these incidents often occurred during activities that took place away from Ashley Youth Detention Centre.<sup>116</sup> He told us that these activities were made available to young people as a reward for good behaviour.<sup>117</sup> Ben believed that design changes to the Centre in the early 2000s meant that sexual abuse was more likely to take place away from the Centre's premises.<sup>118</sup> He soon realised that participating in excursions made him more vulnerable to abuse.<sup>119</sup>

Ben recalled one occasion when a staff member violently sexually abused him and two other young people from the Centre during an off-premises activity.<sup>120</sup> The three boys were not yet teenagers.<sup>121</sup> Ben remembered crying in the backseat of the car on the way back to the Centre. He said that the staff member threatened to hurt the boys again if they did not stop crying or if they told anyone what had happened.<sup>122</sup>

After this incident, Ben said he was too scared to be taken off the Centre's premises and would try to avoid these activities. Ben said it was 'hit and miss [whether] we would be abused or not'.<sup>123</sup> Ben explained that missing an outing often meant being left locked inside all day because there were not enough staff left to supervise the young people who stayed on site.<sup>124</sup>

Ben also recalled a multiday camping excursion during which he was sexually, physically and emotionally abused at least once a day.<sup>125</sup> Ben said he was raped three times on this excursion by an Ashley Youth Detention Centre staff member, Stan (a pseudonym). Ben told us that he knew of at least one other young person who was abused on that trip as well.<sup>126</sup> We discuss the Department's response to allegations raised against Stan in Case study 7.

Ben described the effect of the alleged abuse on him:

By the end of the trip ... me and [my friend] were broken. The trip had destroyed us mentally! All we had been enduring had finally caught up to us on this trip that was supposed to be fun and exciting. Once we got back to Ashley everything was harder. I began to do poorly at school and art and all of the other programs run at Ashley. Slowly I started to notice drastic changes in my beliefs, my thoughts, my actions and my behaviour overall—at [this young age] I felt nasty, I felt like violence was the answer to everything and that rage and anger were normal, that flying off the handle over everything was OK.<sup>127</sup>

Ben said that as his behaviour escalated, he was regularly in trouble at the Centre.<sup>128</sup> He told us he was often restrained by staff and that they targeted him for further abuse.<sup>129</sup> Ben believed that some Ashley Youth Detention Centre staff were not 'adequately assessed or screened' for the work, which sometimes involved dealing with the young people's aggressive and violent behaviours.<sup>130</sup> He said that maintenance staff were sometimes called in to resolve incidents and restrain young people.<sup>131</sup> Ben also recalled regular violent abuse by three staff members in particular, which twice resulted in broken bones and other serious injuries to Ben and other young people.<sup>132</sup>

Ben said that the 'sheer scale and volume of sexual and physical acts committed upon [him at Ashley Youth Detention Centre] is astonishing and devastating', so much so it is a 'blur'.<sup>133</sup> He said that the abuse pushed him into a 'dark place'.<sup>134</sup> He recounted an incident where he and two other young people attempted to die by suicide by breaking into a medication cabinet at Ashley Youth Detention Centre and taking the medication they found.<sup>135</sup> Ben said that the incident resulted in a two-hour stand-off with staff, after which the boys were stripped naked, beaten and put into isolation.<sup>136</sup>

We [were] locked down on 23-hour-a-day lockdowns for weeks on end. Every couple of days we would be belted for the standoff in [the] office and [to] scare us into mercy and [to] never do it again. ... I would be on and off the [behaviour management program] all the time ... when they would lock us down for 23 hours a day in our cells with one book, one pen and pad, a mattress and bedding.<sup>137</sup>

Ben also recalled a violent beating after an escape attempt, during which he was stripped naked, handcuffed behind his back and had his feet cuffed together.<sup>138</sup> He told us that he was left handcuffed and unable to move off the floor for about five hours, before being placed in lockdown for another three weeks.<sup>139</sup>

Ben was transferred to an adult remand centre in his late teens, where he said he was placed with violent offenders and sex offenders.<sup>140</sup> Ben told us that he continued to suffer physical and sexual abuse there.<sup>141</sup>

### 3.1.5 Reporting allegations of abuse at Ashley Youth Detention Centre

During his first admission to Ashley Youth Detention Centre, Ben reported the physical and sexual abuse he said he experienced from other young people in detention to staff.<sup>142</sup> Ben said that, in response, he was restrained, taken to an observation cell and stripped naked by senior staff.<sup>143</sup> He recalled that staff members told him that 'if [he] had to suck dick to survive then [he] shouldn't steal tax payers' cars'.<sup>144</sup> Ben said he learned very quickly to keep his mouth shut.<sup>145</sup>

Ben recalled that after he was hospitalised following an episode of violent sexual abuse, it appeared some steps were taken at Ashley Youth Detention Centre to separate the younger, more vulnerable boys from the older boys.<sup>146</sup> He said this involved placing the younger detainees in makeshift container accommodation, where they had to use buckets as toilets.<sup>147</sup> Ben told us that, eventually, young people charged with sexual offences were placed with these younger detainees and the abuse resumed.<sup>148</sup>

Ben described how he and another young person at Ashley Youth Detention Centre made complaints against two staff members.<sup>149</sup> Police investigations began, but Ben and his friend withdrew their complaints because they feared reprisals.<sup>150</sup> Consequently, these staff members returned to work at Ashley Youth Detention Centre.<sup>151</sup> Ben said that soon after this incident, he suffered a medical event, and doctors ordered that he not be moved due to the significant pain he was in.<sup>152</sup> He said that an hour after that medical advice was given, staff at the Centre and police forced Ben into a car so he could attend a meeting at the local police station.<sup>153</sup>

Ben also recalled instances where privileges were taken away from him when he complained about staff members and that favours were granted when he withdrew his complaints.<sup>154</sup> He told us that people external to the Centre visited every four to six weeks to check on the young people.<sup>155</sup> Ben said he was never asked by these visitors if he was being mistreated and that, even if he had been asked, he knew better than to say anything when he was being observed by Ashley Youth Detention Centre staff.<sup>156</sup>

In addition to his fear of repercussions, Ben also believed that the culture at Ashley Youth Detention Centre among young people discouraged reporting abuse.<sup>157</sup> He said:

I ... wanted to be a criminal, and making complaints is not what criminals do. In a way we wanted to be like the people that were abusing us. We wanted to be big and tough. We believed that we only had one way out and that way was violence. There was also no CCTV cameras, so nothing that happened was recorded.<sup>158</sup>

Ben said that staff saw the young people detained at Ashley Youth Detention Centre as ‘the scum of society’ and that they normalised violence and abuse against young people.<sup>159</sup> He described watching as new staff were absorbed into this system:

... there was the perception that any staff who didn’t follow these rules would not have a job. On countless occasions I witnessed staff new to Ashley be ridiculed by long term staff because they did not join in on restraints. These new staff would quit or get kicked out for not toeing the line. In my opinion they were the sort of people that should have been employed at Ashley. They could have made a difference if they weren’t continually pushed out.<sup>160</sup>

In Ben’s view, operational leaders of the units wielded the most power over the young people at the Centre.<sup>161</sup> He felt that young people had little access or recourse to Ashley Youth Detention Centre management.<sup>162</sup>

### 3.1.6 After Ashley Youth Detention Centre

As an adult, Ben said he was approached by representatives of the Abuse in State Care Program.<sup>163</sup> He was told that making a claim would be trauma-informed and that his best interests would be prioritised throughout the process.<sup>164</sup> Ben recounted some of the abuse he suffered while at the Centre to these representatives.<sup>165</sup> A few days later, Ben told us that he was informed that there had been a mistake and that he was ineligible for the program.<sup>166</sup> He was ‘shattered’. He added:<sup>167</sup>

While I don’t think they did it on purpose, they should have followed up after this monumental mistake. I felt so worthless, confused, and suicidal after this meeting. To me it was like ... there was nothing anyone could do about the horrific sexual and physical abuse I had suffered. This was devastating and has consumed my mind, my thoughts, and my feelings until now. I’d come so far and this [brought] me back so much. It wrecked me.<sup>168</sup>

Ben further recounted that, a few years later, he was visited by lawyers in relation to the National Redress Scheme.<sup>169</sup> He said he was wary about talking to these lawyers because of his experience with the Abuse in State Care Program and that he asked them how they knew he and others had been at Ashley Youth Detention Centre.<sup>170</sup>

Ben is now bringing a civil claim against the State for the abuse he suffered at Ashley Youth Detention Centre.<sup>171</sup> He is frustrated by how long the process is taking:



The length of time that the process has taken makes me feel betrayed and worthless, and I am starting to question the legitimacy of the process and whether it is worth it for me. ... [The Government] are dragging their feet as much as they can. I personally feel like they are weighing up my longevity. They hope that I die of an overdose, die of murder, die in prison – because I chose to go the civil route. I know they won't want to give me a cent. They see it that I've already cost the state money. It doesn't matter what happened to me as a child, it only matters what I have done since then ... The process of trying to seek compensation has eaten me up from the inside.<sup>172</sup>

### 3.1.7 Improving youth detention

Ben wants the Government to acknowledge that it allowed the wrong people to work at Ashley Youth Detention Centre.<sup>173</sup> He wants the Government to ensure people like those who abused him are never employed in institutions like the Centre again.<sup>174</sup>

Ben considers that greater scrutiny of youth detention staff is required.<sup>175</sup> In his view, a National Police Check or registration to work with vulnerable people is not enough.<sup>176</sup>

He also believes that greater care should be taken when placing young people together in detention to ensure they do not pose a risk of harm to each other.<sup>177</sup>

Ben thinks that more community supports would have prevented him from falling into a life of crime, and that these supports are critical for other youth in crisis and to prevent youth detention.<sup>178</sup> Ben also thinks there is a need for more residential facilities for struggling young people.<sup>179</sup> In his experience, existing residential facilities are wary of taking on young people with a history of violence, mental illness or drug use, which has led to the most vulnerable children ending up back in the community without support, destined to return to Ashley Youth Detention Centre.<sup>180</sup>

## 3.2 Case example: Eve

### 3.2.1 Before Ashley Youth Detention Centre

Eve's son Norman (both pseudonyms) had struggled with significant mental health issues from the age of 13, for which he was prescribed medication.<sup>181</sup> Before Norman experienced mental health issues, Eve recalled that Norman was a 'nice, happy, great kid, everyone loved him, got along well with everybody in the community'.<sup>182</sup> After his mental health issues presented, Norman began 'hanging out with a really bad group of people and he made a bad decision' that resulted in criminal charges and a sentence to be served at Ashley Youth Detention Centre.<sup>183</sup>

Norman was admitted to Ashley Youth Detention Centre in the early 2010s when he was 17 years old.<sup>184</sup>

### 3.2.2 Admission to Ashley Youth Detention Centre

When Norman was first remanded at the Launceston Remand Centre (now Launceston Reception Prison), staff refused to accept Norman's medication from Eve.<sup>185</sup> Eve was told that any medications that Norman required would be provided at Ashley Youth Detention Centre.<sup>186</sup> Norman was transferred to Ashley Youth Detention Centre the next day. When Eve called to ask if Norman had received his medication, staff told her they did not have any medication at the Centre and that Norman would have to wait until after the weekend to see the doctor.<sup>187</sup> On Monday, Eve drove from Hobart to Ashley Youth Detention Centre to supply Norman's medication herself.<sup>188</sup>

Although staff eventually gave Norman his medication, Eve said they questioned Norman's mental health diagnosis and the dosage of his medication. She said they gave him a lower dose than his doctor had prescribed.<sup>189</sup> Staff told Eve that an Ashley Youth Detention Centre psychiatrist would have to review the dosage.<sup>190</sup> Eve also recalled being told that the psychiatrist visited the Centre from the mainland every six weeks.<sup>191</sup> She said that it was impossible for Norman to get an appointment with a psychologist at the Centre, and the Centre refused her attempts to get him access to a local psychologist on the basis that he was under state care.<sup>192</sup> She could not recall how long Norman went without receiving his prescribed dosage of medication.<sup>193</sup>

Eve told us that she advocated for her son through every channel at her disposal. She had her doctor write to the Centre regarding her concerns about Norman's mental illness and wellbeing.<sup>194</sup> She also had the Shadow Minister for Children write to the Minister for Children about Norman's history and her concerns.<sup>195</sup> Further, she contacted the Minister directly but did not receive a response.<sup>196</sup> Eve said she also engaged with Ashley Youth Detention Centre staff but did not find them helpful. She said they would block her attempts to get information about Norman's situation or to help Norman.<sup>197</sup> Where she raised concerns about Norman's welfare, the response was to put Norman on suicide watch in a small cell with observations every three minutes.<sup>198</sup>

Eve said she worried that her advocacy for Norman only made things worse for him:

If [Norman] rang and told me things, I continued to call Ashley and let them know I had fears for his safety. The outcome of this would be that they would put [Norman] back on three-minute observations. It became a deterrent for him to tell me things. Every time I rang there would be repercussions for him.

Over time the phone calls between [Norman] and I became less frequent and [Norman] stopped telling me things. In the end he said, 'please mum, stop'. My advocating for [Norman] meant there were repercussions for him. He wouldn't even tell me how he was feeling anymore.<sup>199</sup>

Eve initially visited Norman at the Centre every two weeks.<sup>200</sup> However, Norman asked her to stop visiting because, as she learned later, he would have to endure 'cruel' strip searches after each visit:<sup>201</sup>

So, when I would go and visit, it's a little bit upsetting for a parent to know that, just for a child to come visit its mother in a room, that the guards are going to fossick through their anus and their genitals on their way back out. It wouldn't be something that most people would want to have to happen, and it was—it did feel awful knowing that that did happen every time I visited him, but it wasn't until later on that I found out that there was a lot of bastardisation going on during these searches, I won't go into details, but it was enough to make him not want me to visit anymore.<sup>202</sup>

During Norman's time at Ashley Youth Detention Centre, a detainee died in custody. Eve said Norman heard the detainee being sick in a nearby cell and begging for help, but staff did not assist.<sup>203</sup> Norman told Eve that the other kids heard the detainee whimpering in bed during the night and then the noise stopped.<sup>204</sup> After not showing up for breakfast, the detainee was found dead. Eve said Norman felt really unsafe and was afraid that this sort of thing could happen to him as well.<sup>205</sup> Eve reflected that:

It really affected him. I remember him distressed on the phone. When you're 17, and you hear a friend die, it's going to affect you for the rest of your life. Despite this, none of the kids got proper counselling.<sup>206</sup>

### 3.2.3 After Ashley Youth Detention Centre

Eve described her son before he went to Ashley Youth Detention Centre as 'saveable'.<sup>207</sup> She said: 'He was a child that still could have been turned around and had a future, but they changed that and his future's been pretty awful'.<sup>208</sup>

Eve believes that nothing was done at Ashley Youth Detention Centre to help Norman to address his behaviour and that he 'came out ten times worse than he went in'.<sup>209</sup> She said that:

When he came out, he was a different kid. He wasn't coping. He wasn't acting like himself. He was very angry. He wouldn't speak. There was no happiness in him. He wouldn't tell me what was wrong, but it was clear he was really traumatised.<sup>210</sup>

Eve said that Norman had a lot of bad experiences at Ashley Youth Detention Centre that he does not want to tell her about because he knows how much it will affect her and he doesn't want her to worry about it forever.<sup>211</sup>

Recently, Eve went through the right to information process to try and learn more about Norman's time at the Centre. She believes the records she received show the unwillingness of staff at the time to give her information or constructively address Norman's behaviours. She said the records focus on punishing Norman and satisfying the public perception that young people in youth detention should be treated as 'criminals'.<sup>212</sup>

Eve told us that Norman has recently started engaging with the Sexual Assault Support Service and was talking to them about what happened to him at Ashley Youth Detention Centre more than a decade ago.<sup>213</sup>

### 3.2.4 Improving youth detention

Eve believes that the detention of young people should be therapeutic rather than focusing on punishment.<sup>214</sup> She stated that Norman's behaviour worsened due to a lack of alternative support for young people with mental health issues and the fact that non-violent young people were detained together with violent young people.<sup>215</sup> She said: 'There needs to be a better way of dealing with children than just destroying them in detention'.<sup>216</sup>

Eve also feels the location of Ashley Youth Detention Centre, a three-hour drive from Hobart, is an issue and that there should be facilities in the north and south of Tasmania so children in detention can stay connected to their families.<sup>217</sup> She told us:

As a mother that wanted to stay involved and advocate for [Norman], they cut me off. It's detrimental to children to separate them from their families when they are trying to rehabilitate. Family support when they are released from detention is critical.<sup>218</sup>

## 3.3 Case example: Max

### 3.3.1 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

Max (a pseudonym) was detained at Ashley Youth Detention Centre from the late 2010s to 2021. He was 12 years old when first detained and, at the time, he was the youngest person in his unit.<sup>219</sup> Max told us that, barely an hour after arriving at his unit, he became the target of bullying by other young people in detention.<sup>220</sup> Max said he asked staff if he could be moved elsewhere because he felt unsafe, but they responded: 'If you don't like coming here, then don't do the crime'.<sup>221</sup> To keep himself safe, Max 'locked [himself] down' in his cell until he was released on bail a few days later.<sup>222</sup>

Max returned to the Centre for breaching his bail conditions.<sup>223</sup> Soon after arriving, Max was placed in a unit with three boys who were much older than him, including Floyd (a pseudonym), who Max knew from the community.<sup>224</sup> As soon as Max found out that Floyd was in the unit, he told staff that he was not safe there and would likely be 'bashed'.<sup>225</sup> Max told us that staff refused to move him, saying he 'had no choice'.<sup>226</sup>

Max said that on the same day, Floyd verbally threatened Max.<sup>227</sup> Max recalled that a staff member, Alan (a pseudonym), was present when Max was threatened, but Alan left the room and sat in the office, watching the boys through a window.<sup>228</sup> Max recalled feeling as though Alan 'had purposely walked away from us'.<sup>229</sup> As soon as Alan left the room, Max was assaulted by Floyd and another boy, Ned (a pseudonym), when Max refused to perform oral sex on Floyd.<sup>230</sup> Alan yelled at the boys to stop fighting but did not physically intervene until other staff arrived to assist.<sup>231</sup>

Max was angry and upset that staff had not listened to his concerns about being placed in a unit with Floyd. He said:

I was bleeding from the nose. I started saying to the youth workers, 'I told you this would happen'. They just ignored me and didn't say anything. The thing that really pissed me off was that I told all of the youth workers that it was going to happen but they didn't listen to me. [Alan] heard [Floyd] threaten me. They should have been more aware.<sup>232</sup>

Max refused to press charges against Floyd or Ned for the assault because he thought it was a 'dog thing to do'.<sup>233</sup> He also felt it would just make life harder for him at the Centre and put his family at risk because the boys knew where his mother lived.<sup>234</sup> Max said he was aware that the Centre's management took steps to charge other young people for assaults committed at the Centre, and he does not know why this didn't happen in his case.<sup>235</sup> Instead, Max recalled that as punishment, Ned was dropped a 'colour rating' in the Centre's behaviour management program.<sup>236</sup>

Max was moved to another unit, again with boys who were bigger and stronger than him.<sup>237</sup> He said he was picked on because he had got the boys from the previous unit in trouble.<sup>238</sup> Max told us that on one occasion, a boy, Arlo (a pseudonym), tried to insert a table tennis bat into Max's anus.<sup>239</sup> Max said that the staff at the Centre were aware of the incident and dropped Arlo's colour rating in the behaviour management program, but they did not take any other steps to keep Max safe.<sup>240</sup> Eventually, Max was moved to another unit when he refused to go to bed at the same time as the other boys in the unit.<sup>241</sup>

On a later admission to the Centre, when Max was still aged under 15, he was again placed in a unit with Floyd.<sup>242</sup> Fearful, Max asked the staff why he was being placed with Floyd after what had happened; he was told he was 'exaggerating' and that there were no other units available.<sup>243</sup> Max told us that staff threatened to put him into isolation if he did not calm down.<sup>244</sup> Max said that Floyd apologised for what had happened previously, but Max was still afraid.<sup>245</sup> He recalled:

... I was still scared and thought it was only a matter of time before something else serious happened to me. I don't understand how they could put me back in a unit with someone who nearly raped me. The youth workers knew about it but they weren't even concerned about it.<sup>246</sup>

Desperate to be moved, Max said he intentionally damaged the roof of his cell and was transferred to another unit the next day.<sup>247</sup>

### 3.3.2 Alleged abuse by Ashley Youth Detention Centre staff

Max recalled that, as he got older, the abuse and assaults by other young people at the Centre stopped, but the frequency of physical and sexual abuse by staff increased.<sup>248</sup>

Max said that the lack of surveillance cameras was a big problem at the Centre and that staff knew how to exploit the ‘black spots’.<sup>249</sup> He said that: ‘Nine times out of 10 [those black spots are] where everything happens’.<sup>250</sup> He said staff would regularly take young people to these places to ‘belt’ them, or threatened to do so if the young people did not behave.<sup>251</sup> On one occasion, in the early 2020s, Max recalled being assaulted by staff on a construction site on the Centre’s property—Max believes that this was a deliberate attempt to avoid the assault being caught on surveillance cameras.<sup>252</sup>

Max had been told to ‘talk before you use actions’ to help regulate his behaviour, but, in his experience, Centre staff often did not listen.<sup>253</sup> He recalled one occasion where he had been sent to his room after assaulting a teacher.<sup>254</sup> A staff member asked him what the problem was, to which Max replied that he did not want to talk about it and said that if the staff member did not leave the room Max would hit him.<sup>255</sup> Max told us that the staff member did not leave and Max started towards him, at which point Max was tackled by two other staff who had been outside the room.<sup>256</sup> Max explained that he knew assaulting a staff member was wrong, but he thought the incident could have been avoided if they had listened to him:<sup>257</sup>

... the way they always say, like, if you’ve got something, they say talk about it with case management; they say, ‘talk about stuff before you do something, like, just try and talk about it, talk before you use actions’, so I tried it and it just didn’t work, like. So, there was nothing else for me to do.<sup>258</sup>

Eventually, Max felt that the only way he could keep himself safe was to be moved out of the Centre.<sup>259</sup> He continued to act out, including assaulting staff, until he was sent elsewhere in his late teens.<sup>260</sup>

Max said that he was forcibly strip searched by at least three or four staff members in his cell, where there were no cameras.<sup>261</sup> He recalled that on at least two occasions a staff member inserted a finger into Max’s anus.<sup>262</sup> On one occasion, he told us that staff handled his genitals and searched between his buttocks.<sup>263</sup>

Max remembered another incident when he was dragged to his room following a stand-off with staff. Max told us that when he refused to be strip searched, staff responded that they could ‘do whatever the fuck [they] want’.<sup>264</sup> Max said that none of the other detainees involved in the stand-off were strip searched.<sup>265</sup> He further recalled that, after another incident, staff members ripped his clothes off and started searching him, after which they threw him to the ground and then left him in his cell.<sup>266</sup> Max said he ‘felt disgusting after what [the staff] did’ and that it made him ‘feel like shit knowing that [he] had no power over anything’.<sup>267</sup>

On another occasion, Max recalled that he and another young person were strip searched by Alan and other staff in the breezeway, after they had been caught with cigarettes and drugs.<sup>268</sup> Max told us that he lashed out during the search, at which point Alan punched Max, reminding him that ‘there are no cameras up here’ in the breezeway, and that ‘no one knows what happens up there’.<sup>269</sup>

Max observed that new staff members would quickly adapt to the culture at Ashley Youth Detention Centre.<sup>270</sup> He explained that new staff often started off well, acting nicely towards the young people and not assaulting them, but after a year or so they would ‘normally turn into the same as the other ones’.<sup>271</sup>

### 3.3.3 Reporting allegations of abuse at Ashley Youth Detention Centre

A couple of years after his first admission to Ashley Youth Detention Centre, Max began to engage with the Commissioner for Children and Young People.<sup>272</sup> At first, Max did not want to speak to the Commissioner because he thought it was a ‘dog thing to do’, but he was encouraged when he saw other young people doing it.<sup>273</sup> Max said that Ashley Youth Detention Centre staff did not like the people in detention speaking to the Commissioner and that, once he started doing this, the staff began treating him even more poorly and made it ‘obvious’ that they were punishing him.<sup>274</sup> He said that staff thought that by speaking to the Commissioner for Children and Young People, the young people were ‘trying to get [them] in trouble’.<sup>275</sup>

Max explained that he did not report the abuse by other young people in detention and staff members at the Centre because he thought that no one would believe him. He recalled that a staff member had told him that making a report to the Commissioner was no use because ‘no one will believe you’.<sup>276</sup> Max said that without surveillance footage, he had little hope:

Because there were no cameras, it was just my word against all of the youth workers. When there are three or four youth workers against one resident, people are always going to believe the youth workers. I’m a criminal and they’re government. Everyone is going to believe them. They will just see it as a kid crying wolf.<sup>277</sup>

Max told us he was also scared of the staff at the Centre and how they would react if he were to complain. He felt that the close relationships between staff members meant that they would share information or support one another.<sup>278</sup> He felt that even telling people outside the Centre, including his Youth Justice worker or his lawyer, might result in information getting back to youth detention centre staff.<sup>279</sup> He explained:

The staff at Ashley are all like family to each other. They all know each other from the outside. They aren’t just like work colleagues. They are family and friends or in relationships. That’s why you can’t tell anyone about another staff member. It always gets back to them and it just ends up worse in the end.<sup>280</sup>



Today, Max thinks that failing to complain about what other young people in detention and staff members did to him made him a target:

It was like they saw that I wasn't going to be a dog, so they could do these things to me. I look back now and think that I should have done more about it so all of these things would have stopped. I should have told someone. At the time I felt like if I did tell someone I would have been treated even worse.<sup>281</sup>

More recently, Max has told the Commissioner for Children and Young People about his treatment at Ashley Youth Detention Centre and his view of the way staff at the Centre responded to his contact with our Commission of Inquiry. We discuss Max's complaint in Case study 6.

### 3.3.4 Improving youth detention

Max felt that he 'should have [had] the right to complain' when he was at the Centre, rather than be made to feel as though no one would take him seriously or that he would be harmed if he did so.<sup>282</sup> He thinks that the complaints of young people in detention 'need to be taken seriously' and that more needs to be done to ensure problems are addressed before something serious happens or before it is too late.<sup>283</sup>

Max thinks that if Ashley Youth Detention Centre is replaced, there must be an entirely new workforce employed.<sup>284</sup> He commented: 'You can open a thousand centres but if you keep the same staff there the same stuff is going to happen'.<sup>285</sup>

Max hopes that there will be cameras everywhere in any youth detention centre that replaces Ashley Youth Detention Centre.<sup>286</sup>

## 3.4 Case example: Warren

### 3.4.1 Before Ashley Youth Detention Centre

Warren (a pseudonym) told us that, from a young age, he was regularly physically abused by his mother, who struggled to care for him after he was diagnosed with attention-deficit/hyperactivity disorder (ADHD).<sup>287</sup> Warren was taken from his mother's care and made a ward of the State before he was 10 years old.<sup>288</sup> He was placed with numerous foster families and would steal or run away from them in the hope that he would be sent home.<sup>289</sup>

### 3.4.2 Admissions to Ashley Youth Detention Centre

Warren was first admitted to Ashley Youth Detention Centre in the mid-2000s when he was 13 years old.<sup>290</sup> He was charged with theft and assault while on bail for other offences and was remanded to the Centre for four months.<sup>291</sup> Warren said he was detained at the Centre about 21 times in the 2000s, usually for a couple of months at a time.<sup>292</sup> The longest period he was at the Centre was for about a year, from just before he turned 18 until he was almost 19.<sup>293</sup> Warren's detentions at the Centre were about evenly split between him being on remand and under sentence.<sup>294</sup>

### 3.4.3 Alleged abuse by Ashley Youth Detention Centre staff

Warren said that initially he did not think the conditions at the Centre were too bad.<sup>295</sup> He said he got along with some of the staff really well and that they would treat him like a human being, rather than just a criminal, and try to help him out and keep him out of trouble.<sup>296</sup> Warren said he also learned how to read and write at the school at Ashley Youth Detention Centre and had the opportunity to learn life skills such as woodworking and being a barista.<sup>297</sup>

Warren also said that some staff would ‘bring their bad mood to work’ and would be ‘physical’ with the detainees who they did not like.<sup>298</sup> There was also some violence among the young people detained.<sup>299</sup> Warren said he tried to ‘keep out of stuff’ by staying in his room a lot and avoiding interactions with other people.<sup>300</sup>

Warren said he was sexually abused at the Centre for the first time when he was 14 years old.<sup>301</sup> He recalled that it happened during his second admission while he was being searched.<sup>302</sup> He told us that strip searches, usually conducted by two staff, were ‘degrading and abusive’.<sup>303</sup> Warren said he was forced to strip naked in front of staff and to bend over so they could check for contraband, despite this being contrary to the procedure at the time, which stated that a person in detention only had to expose the top or the bottom half of their body at a time.<sup>304</sup>

Warren said that, starting from his third admission when he was 15 years old, he was abused in his room.<sup>305</sup> He said that three staff members, while giving him medication, forced him to masturbate in front of them.<sup>306</sup> Warren said that the staff would also force him to touch their penises with his hands and perform oral sex on them.<sup>307</sup> Warren also said he was anally raped more than 20 times by one of the staff while other staff members restrained him.<sup>308</sup> He said that the staff would withhold his medication unless he performed sexual acts on them.<sup>309</sup> Warren was supposed to take his medication in the morning and at night. He told us that the sexual abuse would often occur in the morning, and Warren would be required to perform sexual acts on the staff or on himself while they watched, before they would give him his medication.<sup>310</sup> He recalled that such abuse happened to him more than 50 times during his time at Ashley Youth Detention Centre.<sup>311</sup> He also told us that if he did not submit to sexual acts, ‘the guards would arrange for my family to be hurt’ or that they would ‘arrange for older and bigger inmates to bash me’.<sup>312</sup>

Warren said that staff would also physically abuse him by pinning his arms behind his back, hurting his shoulders and ramming his head against the walls.<sup>313</sup>

He said that the staff who abused him were consistently on the same shifts, working together.<sup>314</sup> Warren recalled that the abuse continued throughout his admissions to the Centre until after he turned 18.<sup>315</sup>

Warren said he did not tell anyone what was happening to him at the time.<sup>316</sup> He said that the staff threatened to tell other young people in detention that Warren was informing on them if he disclosed the abuse. He said they also made threats against his family to prevent him from disclosing the abuse.<sup>317</sup>

Warren recalled: 'They would tell me that no one would believe me anyway because I was just a little criminal. I didn't want to say anything because I was afraid of what they could do'.<sup>318</sup>

Warren stated that nobody ever really complained at Ashley Youth Detention Centre because the staff would receive the complaints and tell each other about them.<sup>319</sup> At the time, he did not know of anyone outside the Centre to whom he could complain.<sup>320</sup>

#### 3.4.4 After Ashley Youth Detention Centre

Warren said that since leaving the Centre he has had 'very few achievements' in his life and has struggled with drug use and mental health issues.<sup>321</sup> Warren has also been in and out of prison and has attempted suicide.<sup>322</sup> He said that many of his problems were exacerbated by the abuse he experienced at the Centre.<sup>323</sup>

He said he was almost 30 years old before he began to discuss his experiences at Ashley Youth Detention Centre with his family. He said he has recently engaged with the redress process and counselling, which he has found helpful.<sup>324</sup>

In relation to the impact of his abuse at Ashley Youth Detention Centre, Warren said: 'I have a hard time trusting people. This makes it really hard for me to keep relationships and friendships. I tend to keep to myself and distance myself from people'.<sup>325</sup>

#### 3.4.5 Improving youth detention

Warren told us that many incidents of abuse at Ashley Youth Detention Centre happened in areas that were not covered by closed-circuit television cameras.<sup>326</sup> He thinks that the Centre, or any facility that replaces it, needs more cameras.<sup>327</sup>

Warren also said that the staff need to treat young people in detention better, be better trained and not take their problems out on the people in detention.<sup>328</sup> He said that he never had the same problems with staff in adult prisons that he had with staff at Ashley Youth Detention Centre.<sup>329</sup>

Warren said there needs to be a safe way for young people in the Centre to make complaints, including having someone to speak with who visits from outside the Centre.<sup>330</sup>

## 3.5 Case example: Charlotte

### 3.5.1 Before Ashley Youth Detention Centre

Charlotte (a pseudonym) was 12 years old when she first arrived at Ashley Youth Detention Centre in the early 2000s.<sup>331</sup> At the time, Charlotte's family was 'very broken'.<sup>332</sup> Her parents were in jail and Charlotte was living with their friends.<sup>333</sup> Feeling abandoned and alone, Charlotte began running away and fell in with the wrong crowd.<sup>334</sup> She started shoplifting and stealing cars.<sup>335</sup>

### 3.5.2 Alleged abuse by Ashley Youth Detention Centre staff

Charlotte described her first admission to Ashley Youth Detention Centre as 'the worst time of my life'.<sup>336</sup>

During her first admission, Charlotte said she encountered a staff member, Edwin (a pseudonym), whom she knew from the community.<sup>337</sup> Charlotte described Edwin as 'very sleazy'.<sup>338</sup> She told us that he would often touch her legs under the table and watch her while she showered.<sup>339</sup> Edwin told Charlotte how pretty she was and that he would 'love it if [she] were a bit older'.<sup>340</sup> Charlotte said that Edwin's behaviour made her 'feel yuck' but that she was too scared to report him because she thought her father might hurt Edwin and be sent to jail again.<sup>341</sup> She was also concerned about what Edwin might do if she told anyone about his behaviour.<sup>342</sup>

Charlotte told us that another male staff member at Ashley Youth Detention Centre would also speak and act inappropriately towards her and a friend of hers, who was also in detention. Charlotte said that this staff member would be 'really sleazy, touching our breasts and stuff like that'.<sup>343</sup> She said that on one occasion, he wrote the words 'bite me' across her friend's chest.<sup>344</sup> A female staff member witnessed the incident and reported it.<sup>345</sup> Charlotte wanted to speak to the team leader at Ashley Youth Detention Centre about what had happened, but it was several days before she and her friend could. The team leader shrugged the matter off and responded that the male staff member was no longer at the Centre.<sup>346</sup> Charlotte told us she later found out that the staff member had not been fired. The staff member who had witnessed the assault confirmed to Charlotte that nothing had been done.<sup>347</sup> Charlotte said neither she nor her friend heard anything more about the matter from the Centre's management or the police.<sup>348</sup> Charlotte said she was hurt by the lack of response. She recalled: 'We went to tell someone what happened and nobody cared. We were only little kids'.<sup>349</sup>

Charlotte said that her first admission at Ashley Youth Detention Centre had a significant effect on her.<sup>350</sup> When she was released, Charlotte went to live with friends who had also been detained at the Centre.<sup>351</sup> She began using speed regularly and drinking heavily.<sup>352</sup> She was worried that Edwin would hurt her if she said anything about what had happened at Ashley Youth Detention Centre.<sup>353</sup>

When Charlotte returned to Ashley Youth Detention Centre a second time, Edwin's behaviour was much worse.<sup>354</sup> Charlotte recalled that, on several occasions, Edwin told her that he 'couldn't wait' to go offsite with Charlotte so he could 'do some good things to [her]'.<sup>355</sup>

Charlotte described Edwin as being 'very close' with the male detainees and said that he was known for turning a blind eye to their behaviour.<sup>356</sup> Charlotte recalled that Edwin would regularly bring in cannabis and cigarettes for young people in detention.<sup>357</sup>

On one occasion, Charlotte recalled that Edwin and other staff at the Centre left Charlotte unsupervised with several young people, including older boys.<sup>358</sup> This was not an isolated occurrence. Charlotte recalled that she was regularly left unsupervised with older boys for more than an hour at a time.<sup>359</sup> She told us that, on this occasion, she was sexually abused by an older boy.<sup>360</sup>

Charlotte felt unable to report the abuse because she was sure that friends of the older boy who assaulted her would harm her if she did.<sup>361</sup> Charlotte also felt that even if she did report it, nothing would be done because the young person was a long-term detainee and favoured by staff.<sup>362</sup> Charlotte also said that the staff member responsible for supervision at the time she was detained 'was known to turn a blind eye to pretty much anything'.<sup>363</sup> To keep herself safe, Charlotte isolated herself in her room and her unit.<sup>364</sup> She was depressed and regularly self-harmed.<sup>365</sup>

Charlotte told us she was sexually abused a second time by an older boy from the Centre during an excursion away from the premises.<sup>366</sup> These excursions were common near the end of a young person's sentence and often took place in very remote outdoor places.<sup>367</sup> On this occasion, Charlotte was the only girl in a group of six male young people and supervised only by Edwin.<sup>368</sup> Charlotte said she tried to scream when she was being abused, but no one came to help her.<sup>369</sup> Charlotte did not report the abuse. She explained:

I just had to leave it like that because, if I said anything, [the older boy] would have got other girls in there to bash me that were in there, and if I said anything to Centre staff, obviously nothing was working anyway, so I just had to keep it to myself.<sup>370</sup>

Charlotte was in her mid to late teens when she was admitted to Ashley Youth Detention Centre a third time.<sup>371</sup> On one occasion during her third admission, staff locked Charlotte and other girls in their cells because they were misbehaving.<sup>372</sup> Staff demanded that Charlotte hand over a lighter that she had, threatening to strip search her if she did not hand it over.<sup>373</sup> Charlotte said she had been strip searched before and was scared about it happening again, so she set fire to her cell and cut her wrists.<sup>374</sup> The fire was ultimately extinguished by the building's sprinkler system.<sup>375</sup> Charlotte said that even though the staff could see her covered in blood in the shower (through a viewing panel in the door), they left her alone in her room for four days in her wet clothes, with no bedding and little food.<sup>376</sup>

Eventually, Charlotte was given new clothes and locked down for another week.<sup>377</sup> Upset and confused, Charlotte attempted suicide again.<sup>378</sup> Charlotte told us that a staff member came into her room after her suicide attempt and slammed her head against the bed base, cutting her scalp.<sup>379</sup> Charlotte told us the staff member said that Charlotte ‘deserved it’, that she was ‘a little bitch that needed a flogging’ and that she was ‘making more paperwork’ for the staff.<sup>380</sup>

### 3.5.3 After Ashley Youth Detention Centre

Charlotte said that, upon exiting the Centre after her third admission, she reported some of her experiences to her probation officer.<sup>381</sup> Charlotte left Tasmania soon after and, as far as she is aware, her reports were never addressed.<sup>382</sup>

Charlotte has struggled with anxiety, depression and drug use throughout her teenage years and adult life.<sup>383</sup> She is uncomfortable around men and often reacts with fear when somebody touches her.<sup>384</sup> Charlotte attributes these difficulties to the abuse she suffered at Ashley Youth Detention Centre. She explained:

If it wasn't for how they treated me, I wouldn't be where I am today; using drugs to cover up how I feel and try to forget what happened.

So many times, I've tried to kill myself because of what happened at Ashley. I have lost count.<sup>385</sup>

### 3.5.4 Improving youth detention

Charlotte thinks that more support should be available to children in detention, including giving young people access to somebody to speak to.<sup>386</sup> She feels that she received more support of this kind in adult prisons than she ever received as a 12-year-old at Ashley Youth Detention Centre.<sup>387</sup>

Charlotte thinks that more cultural support for Aboriginal children, like her, would have made a difference.<sup>388</sup>

Charlotte also noted the lack of educational support she received at Ashley Youth Detention Centre, stating that she still struggles to read and write.<sup>389</sup>

## 3.6 Case example: Fred

### 3.6.1 Before Ashley Youth Detention Centre

Fred (a pseudonym) told us he had a tumultuous childhood. He recalled that his father was abusive and physically assaulted Fred and his siblings.<sup>390</sup> Fred's parents separated before he was 10 years old, and he then spent several years moving around the country living with various family members.<sup>391</sup>

Fred had substance abuse issues from his early teens.<sup>392</sup> He told us that, when he was in his mid-teens, his stepfather took out a family violence order against him, and Fred had to move out of the house. Fred became homeless.<sup>393</sup>

### 3.6.2 Admissions to Ashley Youth Detention Centre

Fred was in his late teens when he was first admitted to Ashley Youth Detention Centre in the mid-2000s.

He was charged with stealing a car and remanded in custody because he was homeless and, therefore, could not give the court a fixed bail address.<sup>394</sup> Fred spent three months on remand in the Centre. He was then given bail and released for six months to an independent living placement organised by Ashley Youth Detention Centre.<sup>395</sup> Fred was eventually sentenced to serve another three months' detention on the same charges. Despite having turned 18 by this time, Fred was sent back to the Centre because he had been charged when he was a child.<sup>396</sup>

Fred was placed in the Franklin Unit at Ashley Youth Detention Centre, which he said housed the young people whom the staff had the most trouble controlling.<sup>397</sup> While Fred was not violent, he believes that he was housed in the Franklin Unit because he would 'push the guard's buttons'.<sup>398</sup>

### 3.6.3 Alleged abuse at Ashley Youth Detention Centre

Fred told us he was subjected to numerous strip searches on each of his admissions to Ashley Youth Detention Centre. For every strip search, Fred recalled that he had to strip completely naked. Fred told us that he was often restrained by staff during these searches and subjected to intrusive physical search techniques.<sup>399</sup> Fred recalled three or four staff holding him down, putting their knees on him, running their fingers along his buttocks and genitals, taking off his clothing and asking him to 'squat and cough' as part of searches.<sup>400</sup>

Fred described being strip searched when staff suspected that he had received drugs during a visit, although nothing was found.<sup>401</sup> Fred recalled that the staff began threatening him in an attempt to make him hand over the contraband and comply with the search, with one staff member saying, 'I know where your parents live' and 'we'll make your time harder'.<sup>402</sup> Fred said that the strip searches made him feel belittled and disgusting; he described them as 'harrowing'.<sup>403</sup>

Fred told us that violence between the young people at the Centre occurred daily in the Franklin Unit and that it was often encouraged by staff at the Centre, who did little to stop the fights that broke out.<sup>404</sup> Fred said that the young people in the Franklin Unit called the unit the 'gladiator pit' because it felt like the staff treated fights between them as a sport.<sup>405</sup> In Fred's experience, the Franklin Unit staff waited until a fight was almost over, or until there were more staff present, before taking any action to stop the fighting.<sup>406</sup>



Fred said that on at least two separate occasions he was violently abused by other young people while staff stood by and watched. He said staff then punished him, although he was the victim of the abuse, because he was ‘an annoyance to the unit’.<sup>407</sup>

Fred told us he was also subjected to physical abuse by the staff. He said the staff, who were physically bigger than Fred and most other young people in the Centre, would hit Fred on the back of his head, push him and jump on him.<sup>408</sup> Fred recalled that once, when some young people from Fred’s activity group escaped from the Centre, staff handcuffed him and screamed at him to ‘interrogate’ him for information about the other boys’ whereabouts. He said this reminded him of interrogations shown in films.<sup>409</sup>

Fred told us he witnessed physical and sexual abuse perpetrated against other young people at the Centre. He said he saw a young person at the Centre being raped by another young person, a young person being bashed by other young people, and a staff member dragging a female young person naked from the shower by her hair before placing her on the ground and cuffing her.<sup>410</sup> Fred said that staff generally treated the young people in the Centre roughly, including the younger children who were detained.<sup>411</sup>

#### **3.6.4 Reporting abuse by Ashley Youth Detention Centre staff**

While he was at the Centre, Fred made two written complaints about the misconduct of staff. He said the process for making a written complaint was to ask for a complaint form, fill it out and then slide the complaint under his cell door for a passing staff member to collect.<sup>412</sup> Fred told us that neither of his complaints were acknowledged by Ashley Youth Detention Centre staff or gave rise to any follow-up action. Fred said that, after he slid the complaints under his door, he never saw nor heard about the complaints again.<sup>413</sup>

Fred said that he learned he should not speak out or complain because, if he did say something, staff and other young people at the Centre would ‘come after him’.<sup>414</sup> Shortly after he made his second complaint, Fred was moved from Ashley Youth Detention Centre to Risdon Prison. Fred said that staff at the Centre told him that being sent to Risdon was his 18th birthday present.<sup>415</sup>

#### **3.6.5 After Ashley Youth Detention Centre**

The effect of the abuse Fred endured at Ashley Youth Detention Centre has been significant and ongoing. Fred said he suffers from poor mental health in the form of post-traumatic stress disorder, as well as panic attacks. He feels that his experiences caused him to lose trust in authority figures such as police, prison guards and alcohol and drug counsellors.<sup>416</sup> Fred believes that the physical and sexual abuse he and others suffered at Ashley Youth Detention Centre should not happen to any child:

The things that happened to me at Ashley and the things I saw have affected my mental health. I have flashbacks. These things shouldn't happen to kids, regardless of how naughty we were or how tough we acted. Especially kids that were younger than me.<sup>417</sup>

Fred believes that his time at Ashley Youth Detention Centre and in the youth justice system failed to address his behaviours. Instead, he said his experiences contributed to him falling into a life of crime: 'They never addressed my behaviours. All I did at Ashley was learn how to be a criminal and meet people who led me further down the wrong track'.<sup>418</sup>

### 3.6.6 Improving youth detention

Fred thinks that the Tasmanian Government should move towards a model of managing offending behaviour in children through rehabilitation rather than punitive incarceration.<sup>419</sup> He notes that Tasmania has the highest rate of recidivism among young people in youth detention in Australia and he has no doubt this is due, at least in part, to how Ashley Youth Detention Centre treats its young offenders.<sup>420</sup>

Fred firmly believes that Ashley Youth Detention Centre must be closed:

[The Government should] just close this place down and start again, because it's not—it's systemic, it's grown in that environment. You won't ever get rid of it by putting in new staff members or changing things: tear the place down and start again, the memories are too— just appalling.<sup>421</sup>

## 3.7 Case example: Oscar

### 3.7.1 Admission to Ashley Youth Detention Centre

Oscar (a pseudonym) first went to Ashley Youth Detention Centre on remand for a few months in the mid-2000s when he was 14 or 15 years old.<sup>422</sup> He spent another three months on remand at the Centre about a year after his first admission.<sup>423</sup>

### 3.7.2 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

During his first admission to the Centre, Oscar was initially placed with boys he knew from the community.<sup>424</sup> He was then moved to a unit with boys he did not know.<sup>425</sup>

Oscar recalled that on his second day in the new unit, he went to do some laundry and was physically and sexually abused by five boys.<sup>426</sup> Oscar said that a staff member at the Centre was present and watched the abuse.<sup>427</sup> When Oscar asked for the staff member's help, Oscar recalled that the staff member 'just laughed'.<sup>428</sup> Eventually, the boys stopped abusing Oscar. Oscar said the staff member did not say anything about the abuse that had just occurred; he just told Oscar to go back to his room.<sup>429</sup>

Oscar remained in the unit with the same boys.<sup>430</sup> They continued to bully him, hit him when no one was looking and take his canteen food. Oscar explained that he felt like he ‘was walking on eggshells all the time. The guards were aware of what was happening but would just turn a blind eye’.<sup>431</sup>

Oscar recalled that when the other boys in the unit found out he was receiving a visitor, they pressured him to have drugs and money brought into the Centre for them.<sup>432</sup> Oscar said that they threatened that if he didn’t do this, ‘they would bash the shit out of [him]’.<sup>433</sup>

Oscar said that he never spoke to anyone about the abuse he suffered from other young people detained at the Centre, and he never made a complaint: ‘I didn’t know how to make a complaint and was worried about what would happen if I did. I also didn’t want to be a snitch’.<sup>434</sup>

### 3.7.3 Alleged abuse by Ashley Youth Detention Centre staff

At a visit during his first admission at the Centre, Oscar was given \$20, which staff found after Oscar had initially denied being given anything after he left the visitation room.<sup>435</sup> After they found the \$20, Oscar told staff that he had not been given anything else during the visit; however, he said they replied: ‘We know you’re lying to us and you’ve got other stuff’.<sup>436</sup> Oscar said that staff indicated that they thought Oscar had something hidden in his anus.<sup>437</sup> He recalled that he was then locked in a room near the visitation area that only had a bucket and a desk in it, and he was left there all day:

At end of the day, they came in and asked me if I’d taken a shit in the bucket. I said I wouldn’t go in the bucket. After I refused, they scuffed me and held me down. Then one of the workers who had a glove on stuck his finger up my arse. He said ‘I know you’ve got something in here’. Afterwards, they took me back to my room and locked me in there for the rest of the night and the next day.<sup>438</sup>

Oscar said that he was ‘upset and pissed off’ after the incident and that he knew the way he had been treated was wrong.<sup>439</sup> Oscar did not want to make a complaint because he ‘didn’t know who [he] could trust’ and was worried what would happen to him if he told the ‘wrong’ person, because the same staff would always be on the same shifts together.<sup>440</sup> At the time of giving his evidence to our Commission of Inquiry, Oscar still did not want to name the staff involved in that, or any other, incident.<sup>441</sup>

Oscar recalled being regularly strip searched during his time at Ashley Youth Detention Centre, including at admission and after court and visits.<sup>442</sup> The searches would be done in the admissions area, with two staff members watching Oscar: one in front of him and one behind.<sup>443</sup> Oscar also recalled that staff would search his room if they thought he was hiding something.<sup>444</sup> If they did not find anything, they would strip search Oscar in his room’s shower bay.<sup>445</sup> Oscar said that during these searches, staff members would sometimes ask him to move his genitals; at other times they would do it themselves.<sup>446</sup> Oscar said that he ‘thought it was wrong for them to touch [him]’.<sup>447</sup> Oscar thought he was strip searched in his room like this four or five times while he was at the Centre.<sup>448</sup>

Oscar also recalled being locked in his room on two occasions as punishment for fighting.<sup>449</sup> He said staff would lock him in his room all day and night, only allowing him out once to make a phone call and then making him go to bed at 5.30 pm.<sup>450</sup>

### 3.7.4 After Ashley Youth Detention Centre

Looking back on his experience at the Centre, Oscar said that he does not trust or get along with many people because of the way he was treated there.<sup>451</sup> Oscar said he tries not to think about what happened to him because it upsets him, and he does not like to talk about it; he is trying to get on with his life.<sup>452</sup>

### 3.7.5 Improving youth detention

Oscar said there needs to be better background checks on people who are hired to work at Ashley Youth Detention Centre.<sup>453</sup> He said he believes that some of the staff at the Centre should not have been looking after kids.<sup>454</sup> Oscar said he was always worried about what staff members would do if he complained or spoke up about what happened there.<sup>455</sup>

Oscar said he thinks that places such as Ashley Youth Detention Centre should focus on rehabilitation rather than punishment:

Kids that are in trouble need help to change their behaviours and get a start in life. They should be put into programs and helped to get a job. They shouldn't just be locked up in an institution. Being at Ashley didn't help me in any way. It didn't teach me anything or help me change my behaviours one bit. If anything it made me worse due to the things that happened there and the people I was in with.<sup>456</sup>

## 3.8 Case example: Simon

### 3.8.1 Admissions to Ashley Youth Detention Centre

Simon (a pseudonym) was admitted to Ashley Youth Detention Centre seven or eight times from the early to mid-2000s.<sup>457</sup> Simon was only 10 years old when he was first admitted, on remand for stealing.<sup>458</sup>

On the first and each later admission, Simon was detained at the Centre because he was denied bail, remanded in custody and sentenced while he was at the Centre.<sup>459</sup>

### 3.8.2 Alleged abuse by Ashley Youth Detention Centre staff

Simon told us that strip searches were regularly conducted at the Centre—every time he was admitted, every time he went to and from court, and during random searches of his room.<sup>460</sup> He said that during these searches he had to be naked in front of the staff searching him.<sup>461</sup>

Simon said that, during one search, after he had removed his clothes as requested, the staff asked him to pull his buttocks apart and told him that they would need to hold him down to search him.<sup>462</sup> Simon said he refused and asked the staff to perform a 'normal' search instead.<sup>463</sup> He said that three staff members then came into the room, wrestled him to the ground and spread his buttocks, before putting him in an observation room known as 'the fish tank'.<sup>464</sup> Simon told us that, decades later, he still thinks about that search, how it made him feel abused and how it should never have happened to a child.<sup>465</sup>

Simon said that he was regularly physically abused by Ashley Youth Detention Centre staff, often for minor transgressions such as refusing to go back to his room.<sup>466</sup> Simon told us that staff often responded disproportionately to the actions of the young people in detention; for example, not going to bed on time or 'slipping up [and] doing something simple like a kid does' would lead them to be 'smashed up'.<sup>467</sup> He recalled that staff regularly left him with bruises and grazes.<sup>468</sup> He said that, as well as physically abusing him, staff often called him names such as 'little cunt', which distressed him.<sup>469</sup> Simon told us that he was subjected to verbal abuse 'all the time' while at Ashley Youth Detention Centre.<sup>470</sup>

Simon further recalled staff acting inappropriately towards other young people detained at the Centre. For example, he said that an older staff member would regularly sit and watch young people shower through a viewing panel intended for suicide prevention.<sup>471</sup> Simon said that the staff member became so notorious for this behaviour that he earned the nickname 'dirty old dog' from some young people.<sup>472</sup>

Simon said he was placed in isolation at the Centre two or three times.<sup>473</sup> He recalled being put into isolation as punishment, sometimes for minor transgressions.<sup>474</sup> Simon said he remembers the experience as 'the coldest thing in [his] life that [he has] ever been through', and that it was so cold that it 'felt like it was snowing'.<sup>475</sup> He was only given a horse blanket for warmth.<sup>476</sup> He recalled that, on one occasion, he spent two and a half weeks in isolation.<sup>477</sup>

Simon said he generally did not complain about poor conditions and poor treatment while he was in the Centre because he was afraid that the staff might physically abuse him if he did.<sup>478</sup> He said that, on the occasions he did complain about things the staff did to him, he felt he was not believed because he was a 'criminal' going up against the State.<sup>479</sup>

When Simon was aged 17, he was remanded for robbing a house.<sup>480</sup> When he was told that he was going back to Ashley Youth Detention Centre, he asked to be sent to Risdon Prison instead because he believed he would receive better treatment there.<sup>481</sup> Simon is now in his 30s and has spent more than 15 years of his life in the youth justice and prison system.<sup>482</sup>

### 3.8.3 After Ashley Youth Detention Centre

Simon said that his experiences at Ashley Youth Detention Centre have affected him into adulthood and he feels they have contributed to his long history of incarceration. He told us that the young people detained at the Centre could not defend or protect themselves and were not appropriately supported to improve themselves. He explained:

We were only kids and we couldn't stick up for ourselves. The guards and workers at Ashley were disgusting. I've been in [and] out of jail all my life. I was never taught right or wrong to help me change. I was just abused. I don't want what happened to me happening to another kid.<sup>483</sup>

### 3.8.4 Improving youth detention

Simon said he believes that children and young people who get into trouble should be helped and educated, not punished.<sup>484</sup> He said:

There needs to be a better place for kids who get in trouble to be sent. A place where the kids actually get help to change their behaviour. Somewhere that makes them realise there are better things out there in life. Kids can't stick up for themselves and should be helped ...<sup>485</sup>

Simon said that Ashley Youth Detention Centre could introduce courses and programs to help young people rehabilitate and he believes that he might not be stuck in the prison system now if he had been given that opportunity—he would have had a chance to lead a 'normal' life.<sup>486</sup>

He said Ashley Youth Detention Centre should not be converted into an adult prison after its planned closure, because there is a significant number of adults in prison who spent time at the Centre when they were younger and were assaulted or sexually abused there.<sup>487</sup> Simon said he is concerned that if those adults were sent to a prison on the same site, it could trigger past trauma. He worries that: 'They will put their head down on their pillow at night and think about what happened to them as kids. They will have flashbacks. The whole place should just go'.<sup>488</sup>

Simon said he thinks the Centre should close as soon as possible to avoid causing trauma to more children. He explained: 'I want them to realise they can't treat kids like they did. I don't want other kids to be put [through] what I went [through]. I think the place should be shut down now'.<sup>489</sup>

## 3.9 Case example: Erin

### 3.9.1 Admissions to Ashley Youth Detention Centre

When Erin (a pseudonym) was 14 years old, she was living in a women's shelter after acting up at school and becoming estranged from her mother.<sup>490</sup> Erin's behaviour escalated quickly; she was arrested for stealing and remanded at Hobart Remand Centre (now Hobart Reception Prison) in the mid-2010s.<sup>491</sup> She recalled that the court 'didn't know what to do' with her; a placement in foster care, in a shelter or living with her parents were not seen as suitable options for Erin.<sup>492</sup> After two days at the Hobart Remand Centre, Erin was sent to Ashley Youth Detention Centre on remand for three months.<sup>493</sup>

Erin told us that she was initially comforted by the idea of leaving the Hobart Remand Centre and going to the Centre. She said: 'I was relieved. I thought going there would provide me with some security. I thought Ashley would be better, but it turned out to be worse'.<sup>494</sup>

After her first admission, Erin was admitted to Ashley Youth Detention Centre another three times.

### 3.9.2 Alleged abuse by Ashley Youth Detention Centre staff

Erin said she was strip searched by male staff on her arrival and placed in the female unit.<sup>495</sup> The male detainees yelled at her and banged on her windows.<sup>496</sup> She said she later learned that the males in detention could watch her through the staff office that separated the girls' unit from the boys' unit.<sup>497</sup>

Erin told us that 'if the guards didn't like you, they would do things like leave you in your cell on the weekend'.<sup>498</sup> She said she was once 'unit bound' for a week and only allowed out for an hour or two a day.<sup>499</sup> She stated that this experience has left her traumatised.<sup>500</sup>

Erin recalled frequent strip searches by male staff, during which she would be naked.<sup>501</sup> Erin said she was strip searched each time she was admitted to Ashley Youth Detention Centre and before and after going to court.<sup>502</sup> She said she was also subjected to random strip searches.<sup>503</sup> Erin said she was often strip searched by multiple male staff, who told her they all had to be there for her safety, but Erin felt they treated the strip searches 'like a show'.<sup>504</sup> She described the experience as 'totally violating'.<sup>505</sup> Erin said that she was never given the option of being strip searched by female staff.<sup>506</sup> Erin said that at the time she thought the strip search procedure was normal because she had had the same experience at the Hobart Remand Centre.<sup>507</sup>

Erin described the environment at the Centre as 'hostile'.<sup>508</sup> She said she regularly saw staff physically abuse male detainees.<sup>509</sup> Erin described staff members' attitudes and behaviours towards her as more 'manipulative'.<sup>510</sup> She recalled that staff members



would intentionally cause her to miss meals, leave her in her cell on the weekends and regularly make offensive or inappropriate comments about her body.<sup>511</sup> Erin described being ‘treated like an object’ by staff.<sup>512</sup> She said that during her detention she was never provided with a bra, was not allowed tampons and was only provided with a certain number of sanitary pads at a time.<sup>513</sup> Erin reflected that ‘[t]here were no rights or dignity. It was disgusting’.<sup>514</sup>

Erin told us that, about a month after arriving at the Centre, she was feeling unwell and was worried she had appendicitis.<sup>515</sup> She said she told a male staff member and asked to see the nurse.<sup>516</sup> Instead of arranging access to a nurse, she said the male staff member told her to lift her top up, felt around her lower abdomen and drew a shape near her hip, telling Erin it was a ‘happy appendix’.<sup>517</sup> Feeling violated and that his actions were ‘creepy’, Erin reported the incident to a female staff member, who advised Erin to report it to the Ombudsman.<sup>518</sup>

Erin told us that the same male staff member entered her room to collect sheets while she was showering, despite Erin’s request that he send a female staff member to collect the sheets, or that he waited until she finished showering.<sup>519</sup>

Erin reported these incidents to the Ombudsman, who responded by letter two weeks later, stating that the matter would be resolved by Ashley Youth Detention Centre management.<sup>520</sup> An internal investigation by management found that the male staff member had not displayed ‘inappropriate intent’ in either case, but that he should have known his actions might make Erin ‘feel uncomfortable and even potentially unsafe’.<sup>521</sup>

Erin said nobody at the Centre spoke to her about her complaint, she did not receive any counselling or other supports, and she was not notified of any outcomes.<sup>522</sup> Erin said that she heard from another staff member that the male staff member was placed on two weeks’ paid leave as a result of her complaint, but that this was never confirmed for her by the Ombudsman or by the Centre’s management. We discuss the management of Erin’s complaint to the Ombudsman further in Case study 7.<sup>523</sup>

Erin told us that when the male staff member returned from leave, she had to continue engaging with him and that he was ‘never nice to [her] again’.<sup>524</sup> She said that other staff were angry at her for reporting the incidents, calling her a ‘dog’ and a ‘drama queen’.<sup>525</sup> This made Erin feel as though complaining only created problems:

After this I felt like it was pointless making complaints or speaking up. I learned that you don’t say anything in Ashley, it was more trouble than what it was worth. I would describe the staff at Ashley as being like a pack of animals. Some of them had been working there for 30 years. They all went to school together. They were all from Deloraine, which was a small country town. They all looked after each other.<sup>526</sup>

### 3.9.3 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

There were few girls at Ashley Youth Detention Centre when Erin was detained. She said that this meant she was often in the company of males in detention when taking part in educational or therapeutic programs.<sup>527</sup> Erin said that, on one occasion, she was left unsupervised in a room with 10 males in detention and was sexually abused.<sup>528</sup> She said that it ‘was probably only 2 or 3 minutes but it was enough time for them to do significant damage’.<sup>529</sup>

Erin said she shared what happened to her with another young woman in detention, who then told a female staff member.<sup>530</sup> Erin said that although she asked the staff member not to tell anyone, the staff member reported the incident to management.<sup>531</sup> Erin said she was not offered counselling support or medical treatment, and no one else from the Centre spoke to her about the incident.<sup>532</sup> Instead, she was released a few days later.<sup>533</sup>

Erin returned to Ashley Youth Detention Centre some weeks later on a charge of stealing.<sup>534</sup> She said she was told that the boy who had been predominantly responsible for the sexual abuse during her previous admission had gotten into trouble.<sup>535</sup> Once Erin arrived, the boy’s friends began threatening her and she was confined to her room for her safety.<sup>536</sup> She said she also felt targeted by the staff members who had been reprimanded for allowing the incident to occur.<sup>537</sup> She said this treatment reinforced her view that it was better to stay silent. Erin reflected:

I wasn’t offered any support or protection to help me deal with all of this. There was no-one there to support me. This again confirmed to me that you don’t say anything at Ashley. If things happen you don’t talk, you just go along with it.<sup>538</sup>

Erin was admitted to Ashley Youth Detention Centre two more times, each time for breaching her bail conditions.<sup>539</sup> She said that sexual abuse by male detainees continued during these admissions.<sup>540</sup> Erin told us that staff were aware of what was occurring but that ‘they just accepted it’, enabling the boys to get away with what they wanted.<sup>541</sup> Erin recalled that she was regularly forced to perform sexual acts on males in detention during scheduled programs while staff members watched.<sup>542</sup> Erin said that eventually she was placed on the contraceptive pill and recalled that she visited the nurse’s office each day to receive it.<sup>543</sup>

Erin said she never tried to report sexual abuse again:

I went along with doing these things because I just thought it was easier. I believed that if I didn’t, I would get my head kicked in. It was easier to comply. I didn’t make complaints to the staff because I knew if I did things would get worse. Again, I was fearful of being physically assaulted.<sup>544</sup>

### 3.9.4 After Ashley Youth Detention Centre

Erin said that, after leaving the Centre, she tried to forget her experiences by using alcohol and drugs.<sup>545</sup> Erin has post-traumatic stress disorder, anxiety, depression and low self-esteem. She struggles to trust men, which affects her personal relationships and her children.<sup>546</sup>

Erin said she attributes her poor mental health and wellbeing to the way she was sexualised and sexually abused at Ashley Youth Detention Centre.<sup>547</sup> Reflecting on the impact of her abuse, Erin stated:

Ashley made me feel like it was normal and it was okay for men to treat me like that. It made me believe that it was what I was used for. I have had horrendous things happen to me that I have just thought I deserved. I believed that it was normal for these things to happen because that's how I was treated at such a young age. Before I went to Ashley, I was never exposed to sexual abuse.<sup>548</sup>

### 3.9.5 Improving youth detention

Erin expressed her view that Ashley Youth Detention Centre would be much safer for young women in detention if they were kept separate from males in detention, if there were more female staff, and if staff were better trained.<sup>549</sup>

Erin said that children should not be detained for minor offences and that alternative options to institutional detention, such as home detention, are needed.<sup>550</sup>

She also said that a commitment to therapeutic-based systems must be more than mere words; it needs to be evident in the systems and processes in place at Ashley Youth Detention Centre or any new youth justice facility.<sup>551</sup> She recalled that Ashley Youth Detention Centre was said to be operating a 'therapeutic model' when she suffered abuse there.<sup>552</sup> She said: 'Building a new centre and putting a ribbon on it isn't going to change anything. They need to break it right down and make sure it changes'.<sup>553</sup>

## 3.10 Case example: Jane

### 3.10.1 Before Ashley Youth Detention Centre

Jane's youngest daughter Ada (both pseudonyms) was bubbly, outgoing and well liked for most of her primary school education.<sup>554</sup> Jane told us that Ada became uncontrollable soon after she started her schooling in Tasmania in the late 1990s, aged 11.<sup>555</sup> Ada spent much of her time trying to fit in with older kids, smoking, drinking and not attending school.<sup>556</sup>

Jane reached out to the Department of Education for assistance, hoping they could encourage Ada to go to school.<sup>557</sup> However, Jane said that the departmental employees sent to speak with her and Ada told Ada to 'not worry about schooling' and to 'focus on [her other] problems instead'.<sup>558</sup>

Jane became concerned that she could no longer keep Ada safe and in school.<sup>559</sup> She described feeling ‘betrayed’ after she sought help from the Department of Education and two social workers who visited told Ada not to worry about school and to focus on addressing other problems.<sup>560</sup> She was later told by the Department of Education that the social workers were students and that the Department considered Ada’s non-attendance a serious concern.<sup>561</sup> Jane recalled that, after finding Ada’s behaviour uncontrollable and fearing for her safety, she decided to ‘get welfare involved’.<sup>562</sup> She described being assisted to put together an application and ultimately applied to make Ada a ward of the State when Ada was aged 12.<sup>563</sup> At around this time, a psychological assessment found that Ada’s behaviour was consistent with that of a primary alcoholic.<sup>564</sup>

### 3.10.2 Admissions to Ashley Youth Detention Centre

The same year, while she was a ward of the State, Ada was admitted to hospital with severe alcohol poisoning.<sup>565</sup> Jane said that, after five days in hospital, Ada’s behaviour was deemed too problematic for the hospital to manage, and Child and Family Services approved Ada’s transfer to Ashley Youth Detention Centre.<sup>566</sup> While Jane told us that Ada was admitted to Ashley Youth Detention Centre, we understood her to mean that Ada was admitted to the former Ashley Home for Boys (which was the relevant institution at this time). Jane recalled that Ada’s Child and Family Services’ case workers agreed that this transfer ‘wasn’t right’ but explained to Jane that Ada had been moved to the Centre because there was nowhere else for her to stay while they considered what to do with her.<sup>567</sup>

The Department told us Ada was admitted to the Centre under section 39(7) of the *Child Welfare Act 1960*.<sup>568</sup> We were told the decision to admit Ada was made to address her complex behavioural and medical needs, was based on expert recommendations and was not a decision that was taken lightly.<sup>569</sup>

Jane told us that Ada resisted being transported to Ashley Youth Detention Centre and was therefore restrained during the trip.<sup>570</sup> Jane said that, once at the Centre, Ada was placed in a single cell with other young people. Jane’s recollection was that Ada was subjected to the same rules, such as rules relating to isolation and searches, despite not having been charged with any crime.<sup>571</sup> We were told that Ada was the only female young person detained at Ashley Youth Detention Centre at the time.<sup>572</sup>

Ada was detained at the Centre on and off in the late 1990s and 2000s. Her first admission lasted around two and a half months.<sup>573</sup> Jane told us that, eventually, Ada was transported every day from Ashley Youth Detention Centre to a house, where she was cared for by a case worker or a foster carer. She was then transported back to the Centre every night.<sup>574</sup> Jane recalled she was not allowed to visit Ada during her first admission but visited her at the day home.<sup>575</sup>

Ada was placed with a foster family full-time.<sup>576</sup> A couple of weeks into that placement, Ada ran away for several days until Jane tracked her down and convinced her to go back to the foster home.<sup>577</sup> In response to her running away, Child and Family Services decided that Ada would be detained at Ashley Youth Detention Centre again each night for two weeks and returned to her foster family during the day.<sup>578</sup>

After Ada left Ashley Youth Detention Centre, she returned to Jane's care. Ada was later charged with burglary offences and put on a probation order, with conditions that included not drinking alcohol.<sup>579</sup> The only support the State offered Ada for her alcoholism was counselling. However, Jane stated that Ada, then 13 years old, was left to decide whether she would access counselling.<sup>580</sup> Ada soon breached her probation and was sentenced to a few months' detention.<sup>581</sup>

Jane believes the State set Ada up for failure by neglecting to give her the tools she needed to comply with her probation order. Jane said: '[Ada] had a major drinking problem and they didn't put anything else in place to help her stop. All of these rules had been set up that she would never be able to comply with'.<sup>582</sup>

Jane believes what happened to Ada at Ashley Youth Detention Centre is Ada's story to share, not Jane's.<sup>583</sup> While Jane does not know all the details, Ada has told Jane she had some 'bad times' at the Centre, that she had to be 'tough' when she was there, and that she had to 'fend off some older boys', including males over the age of 18.<sup>584</sup> Ada also told Jane that the increasing number of older people being detained, especially people over the age of 18, created a 'hierarchy' based on age groups and resulted in the older kids causing trouble.<sup>585</sup> While Jane thinks there was more supervision for Ada because she was the only girl at Ashley Youth Detention Centre, she believes the Centre was an entirely unsuitable place for a vulnerable child.<sup>586</sup>

### 3.10.3 Out of home care

Jane told us the State's decisions for Ada were often inconsistent and poorly communicated to Ada.<sup>587</sup> Jane described one instance where Child and Family Services told Ada she would be placed in independent living on release from Ashley Youth Detention Centre. Jane told us Child and Family Services then changed its mind a week before Ada was released and instead transferred Ada to a women's shelter.<sup>588</sup> Jane said these changes were confusing for Ada, would cause Ada to get angry or upset, and in Jane's opinion, set Ada back.<sup>589</sup>

Jane thinks Ada was not supported well enough as a ward of the State. She described how, on one occasion, when Ada was released from youth detention at the age of 14, Ada had to make her own arrangements to be picked up from the Centre because Child and Family Services had not put any transit arrangements in place for her.<sup>590</sup>

Jane also feels there was poor communication and coordination between the different services with which Ada interacted, including Child and Family Services, the Department of Education, the Department of Justice and police.<sup>591</sup> Jane was particularly frustrated by the State's failure to support Ada in her education:

They just didn't have the facilities to deal with kids like [Ada] and as a result the system was failing them. There was never a push to get [Ada] back into school. The education department had told her to sort her issues out and not worry about school. There was no education under the care of [Child and Family Services] and as a result [Ada] didn't complete primary school.<sup>592</sup>

Jane recalled that Child and Family Services allowed Ada to do things that Jane and Ada's foster carers would not, given her young age.<sup>593</sup> For example, Jane was aware that Child and Family Services would buy cigarettes for Ada when she was in her early teens.<sup>594</sup> On one occasion, Jane told us that Child and Family Services gave Ada permission and spending money to go on a two-day trip with a female and three males who were much older than her.<sup>595</sup> When Jane confronted Child and Family Services about this, she was told that the trip had been approved because one of the males, a 19-year-old, had a driver's licence.<sup>596</sup> Jane felt that Child and Family Services failed to listen to or consult her about Ada's care, and let Ada do things that she didn't have the maturity to do.<sup>597</sup>

### 3.10.4 Improving youth detention and out of home care

Jane thought that by making Ada a ward of the State, Ada would be safe and educated.<sup>598</sup> Looking back, Jane feels betrayed by Child and Family Services' decisions to treat Ada like a detainee even though, for much of her time at Ashley Youth Detention Centre, she had not been charged with any crime.<sup>599</sup> Ada now battles an addiction to methamphetamine, which Jane attributes to Ada being caught up in 'the system' and spending time at Ashley Youth Detention Centre.<sup>600</sup>

Jane wants the Tasmanian Government to reduce its reliance on the criminal justice system to work with young people who have complex needs, in favour of alternative interventions and prioritising education.<sup>601</sup> Jane would also like the Government to focus on addressing the cause of youth offending, such as treating Ada's alcoholism.<sup>602</sup>

Jane also believes the various Tasmanian Government departments responsible for children and the out of home care, education and youth justice systems must work together in a child-centred way. She said:

... these are youth that need help, you know, but [through] a combination of all the services working together and [communicating] ... [Ada] didn't finish primary school and she hasn't got an education, and she was extremely bright but she just didn't get that education that I would have liked for her and I think there could have been a lot more done about that.<sup>603</sup>



## 3.11 Case example: Otis

### 3.11.1 Admissions to Ashley Youth Detention Centre

Otis (a pseudonym) was detained at Ashley Youth Detention Centre twice in the early 2010s.<sup>604</sup> He was 16 or 17 years old when he was first detained and 17 years old when he was detained a second time. In total, he was detained for several months.<sup>605</sup>

### 3.11.2 Alleged abuse by Ashley Youth Detention Centre staff

Otis recalled being regularly strip searched at the Centre—on each admission and before and after leaving the Centre’s premises.<sup>606</sup> During searches, Otis said staff required him to be naked and instructed him to squat or ‘stand like [he was] riding a motorbike’.<sup>607</sup> Otis recalled that staff would then perform an intrusive cavity search, including putting their fingers in his anus.<sup>608</sup> Otis said that if he did not comply with instructions, the staff would hold him down to perform the search and that they sometimes deliberately made it more painful and more sexual.<sup>609</sup> It appeared to Otis that some staff enjoyed strip searching him.<sup>610</sup> Otis recalled that because the strip searches occurred so regularly at the Centre, ‘[at] the time I just thought the searches were part of what goes on. I thought it was normal. I didn’t realise it was illegal like I do now’.<sup>611</sup>

Otis said that, on his second admission to the Centre, he was placed in a unit with young people who were afforded more privileges than most because they were well behaved.<sup>612</sup> These young people were offered extra comforts such as DVD players in their rooms and more exercise time.<sup>613</sup> The unit was not as heavily supervised as other units, and it received more funding.<sup>614</sup> At the start of Otis’s admission, the unit did not have any closed-circuit television cameras.<sup>615</sup>

Otis told us that his first experience of sexual abuse was from staff working in that unit, after he opted to stay in his room instead of going to a class, to avoid problems he was having with other young people.<sup>616</sup> Otis said that a staff member entered Otis’ room and told him that he would need to do the staff member ‘a favour’ for letting him stay out of class.<sup>617</sup> Otis said that the staff member then made Otis perform oral sex on him and told Otis that ‘it was a secret and he’d look after [Otis] if [Otis] kept it a secret’.<sup>618</sup> Otis recalled that the staff member also told him that if he did not keep it a secret, the staff member would tell the other young people in detention that Otis had ‘dobbed’ on the other boys.<sup>619</sup>

Otis told us that, after this first incident, he experienced further sexual abuse at the hands of other staff at the Centre.<sup>620</sup> He recalled being made to perform sexual acts on staff and engage in sexual intercourse with staff in his room, in a storeroom, during relaxation therapy group sessions and outside his unit on the Centre’s grounds.<sup>621</sup> Otis said that usually, when he was sexually abused, it was just him and the abusing staff member.<sup>622</sup> Otis also recalled a ‘gang of perpetrators’ that he described as having a ‘gang mentality’.<sup>623</sup>



Otis also recalled being sexually abused by Ashley Youth Detention Centre staff during weekly excursions away from the Centre, and witnessing staff sexually abusing other young people in detention during these excursions.<sup>624</sup> Otis said that the abuse started happening outside their rooms, in storerooms or on excursions once cameras were installed in the unit where he was detained.<sup>625</sup>

On some occasions, Otis and other young people were taken off the Centre's grounds to perform community service.<sup>626</sup> Otis said that the staff member accompanying them took advantage of this time to sexually abuse them.<sup>627</sup> He told us that, when he was taken off site during the early 2010s, he would be separated from the group, held in a car and sexually abused.<sup>628</sup> He said because there was no oversight, staff 'would get away with an extreme amount of shit'.<sup>629</sup> Otis described yelling out to another staff member for help following an incident of sexual abuse when he was left alone with one particular staff member when off site.<sup>630</sup> Otis told us that, in response, this staff member physically assaulted Otis and urinated on him.<sup>631</sup> Otis said that staff would also threaten to leave a young person off the grounds or to tell the Centre's management that the young person had 'run away' if they did not submit to the abuse.<sup>632</sup>

Otis said that he and other young people in detention were bribed with cigarettes and alcohol to stay quiet, and they were physically abused if they complained about the sexual abuse.<sup>633</sup> Otis said that it was well known among the young people in detention that going 'off-property' would mean being sexually abused, but that they would come back with cigarettes for everyone.<sup>634</sup>

Otis recalled being sexually abused almost every time he was taken off-property.<sup>635</sup>

### 3.11.3 Reporting abuse at Ashley Youth Detention Centre

Otis said he felt he could not share the details of his abuse with anyone at the Centre because it would affect his living conditions; the staff who sexually abused him were in control of his television time, his bedtime and his life.<sup>636</sup> He told us that he wanted to stay in his more relaxed unit at the Centre and he was aware that, because he was aged 17 at the time, he had to be well behaved to avoid being transferred to the adult Risdon Prison.<sup>637</sup> Otis said that, when the staff were not content with the sexual acts he was performing, they became physically violent and threatened to take away his bedding or his canteen privileges.<sup>638</sup> Otis believed that his fear of retribution and, in turn, his lack of retaliation, caused staff to continue to sexually abuse him.<sup>639</sup>

Otis said he had heard that young people in detention at Ashley Youth Detention Centre were suffering sexual abuse long before he was admitted to the Centre.<sup>640</sup> He said that sexual abuse was embedded in the everyday behaviour of the place.<sup>641</sup> He said that the young people in detention knew not to 'dob' on anyone:

We ... had a code in Ashley that you don't dob anyone in. The [staff] knew that we had this code, so they knew that we wouldn't speak up. I think they treated us the way they did to show us that they had all the power, and that we had none.<sup>642</sup>

Otis said he eventually reported the abuse to a psychologist at the Centre, although he did not share all the details of his sexual abuse.<sup>643</sup> Otis recalled that the psychologist did not believe him and accused him of being a compulsive liar.<sup>644</sup> He said the psychologist told him not to tell his family about his abuse.<sup>645</sup>

At the time, Otis did not tell his family about the abuse. Otis said: 'I couldn't tell mum about what was happening, and I still haven't been able to tell her some stuff to this day. I got myself into Ashley because I wanted to be a cool kid and do crime. I just didn't expect this stuff to happen'.<sup>646</sup>

### 3.11.4 After Ashley Youth Detention Centre

Otis said that after being sexually abused at the Centre, he has been confused about his sexuality because he felt that he 'accepted' the abuse from male staff.<sup>647</sup> For example, Otis would sometimes offer himself up to go off-property or to the storeroom, where he knew he would be sexually abused, in the place of a younger person who had not been at Ashley Youth Detention Centre before.<sup>648</sup> Otis said he was prepared to endure the abuse rather than watch others go through it.<sup>649</sup>

Otis said he also continues to feel distressed by the death of a fellow young person in detention at the Centre.<sup>650</sup> Otis said the Centre did not offer any counselling or support to other young people in detention following the death.<sup>651</sup> Otis told us that the circumstances before and after the young person's death were 'handled atrociously' by staff at the Centre.<sup>652</sup> He said the incident 'still haunts' him.<sup>653</sup>

Reflecting on his mental health issues following his time at the Centre, Otis said:

I was in detention because I did the wrong thing. That should have been my punishment, not the abuse that I had to endure. It's changed who I am as a person. My self-esteem and personality have been affected. It's impacted my mental health. I've lost faith in people. I was failed hard. I'm still suffering to this day for the things that happened to me.<sup>654</sup>

### 3.11.5 Improving youth detention

Otis said that the sexual abuse of young people in detention was allowed to happen in Ashley Youth Detention Centre because of a lack of oversight.<sup>655</sup> He told us that, in contrast with adult prison, where a strict system of approvals and bookings applies, Ashley Youth Detention Centre staff were allowed to put detained young people in a car and drive them wherever they wanted, with no checks and balances.<sup>656</sup> Otis said he believes the Centre should be run in a more organised manner, where everything requires approval, such as occurs in an adult prison.<sup>657</sup> Otis told us that he wants young

people to be accompanied by at least two staff members at all times when going off-property and for proper approval processes accompanying such trips to be introduced at Ashley Youth Detention Centre.<sup>658</sup>

Otis said that, in the past, he has not been comfortable speaking about his experiences of sexual abuse at the Centre.<sup>659</sup> However, he said that, with the assistance of a counsellor, he has reached a point in his life where he wants to talk about what happened, so others are not subjected to similar abuse.<sup>660</sup> Otis said: ‘I want to know who allowed these things to happen. I don’t care about money. Money doesn’t solve problems ... I worry about what will happen if my kids end up in detention like I did’.<sup>661</sup>

## 3.12 Case example: Brett

### 3.12.1 Before Ashley Youth Detention Centre

Brett was taken into the care of the Department when he was in his first year of high school because of his father’s mental health issues.<sup>662</sup> However, he regularly ran away from his placements because of his experiences, trying to find a way back to live with his father.<sup>663</sup> In Chapter 8, we discuss Brett’s experiences of abuse in out of home care. He said he ended up sleeping rough and stole to survive because he had no income.<sup>664</sup>

### 3.12.2 Admission to Ashley Youth Detention Centre

Brett had just turned 14 when he arrived at Ashley Youth Detention Centre in the late 2000s.<sup>665</sup> He was remanded to the Centre after being charged for an armed robbery he said he committed to finance a plane ticket to the mainland.<sup>666</sup>

### 3.12.3 Alleged abuse by Ashley Youth Detention Centre staff

Brett said he was strip searched by a staff member on admission, and when Brett resisted taking off his boxer shorts, the worker physically abused him. Forcibly removing Brett’s shorts, Brett recalled that the staff member then inserted his finger in Brett’s anus, saying, ‘Welcome to Ashley, boy, you do as you’re told’.<sup>667</sup>

Brett said he went to Ashley Youth Detention Centre six times between the ages of 14 and 17.<sup>668</sup> Brett described his treatment by staff during his time at the Centre as ‘horrible’.<sup>669</sup> He recalled constant belittling comments such as being called a ‘drug baby’ and being told that he wasn’t wanted, as well as physical abuse such as being hogtied for minor infractions such as not moving fast enough back to his room.<sup>670</sup> Brett described being kept in isolation in his room, under what was termed an ‘Individual Support Program’, for up to six weeks at a time.<sup>671</sup>

### 3.12.4 Reporting allegations of abuse at Ashley Youth Detention Centre

Brett described trying to complain to staff about his treatment in youth detention but stopped because ‘it made it 100 times worse’ when staff responded by making life even harder. He said was not aware that he could complain to the Ombudsman at that time.<sup>672</sup>

### 3.12.5 After Ashley Youth Detention Centre

Brett said that his experiences at Ashley Youth Detention Centre led him to distrust the justice system and police—‘the ones that are supposed to help are the ones you’re trying to escape from’.<sup>673</sup>

Brett said he has been incarcerated multiple times as an adult.<sup>674</sup> He said that he has used drugs to try to ‘escape from it all’ and attempted suicide.<sup>675</sup>

### 3.12.6 Improving Ashley Youth Detention Centre

Brett expressed the desire for improved safety at Ashley Youth Detention Centre because of the impact that the experience has had on his life, stating, ‘it’s wrong ... it’s destroyed my life and it’s destroyed many other lives that I know’.<sup>676</sup> He recommended more cameras in Ashley Youth Detention Centre and that the Centre employ staff ‘who understand how to work with children’.<sup>677</sup> He wants children to get help before they get to youth detention.<sup>678</sup>

## 3.13 Common themes

The accounts of abuse we have outlined here predominantly occurred between the early 2000s and the early 2020s (except in relation to Ada, who was detained at Ashley Home for Boys in the late 1990s and then at the renamed Ashley Youth Detention Centre in the early 2000s). Yet, we observed commonalities in the allegations of abuse made by these victim-survivors and their families, as well as in the allegations made through the Abuse in State Care Program, Abuse in State Care Support Service, National Redress Scheme, civil claims and other complaints. We describe some of the common themes from these accounts below. We urge the Tasmanian Government to reflect on these themes when responding to current and future allegations of abuse, and when planning and implementing reforms relevant to youth detention.

More than two-thirds of victim-survivors in the accounts we have documented were under the age of 14 when they were first detained at Ashley Youth Detention Centre. One of the victim-survivors, Simon, was only 10 years old on his first admission.<sup>679</sup> Most of these children were initially detained at the Centre on remand for relatively minor charges, and some of them were never detained under sentence. In the case of Ada, who was only 12 years old when she was first admitted to the then Ashley Home for Boys, her mother Jane recalled that she was not subject to any criminal charges, although the Department told us she was there on specialist advice. Many of the victim-

survivors were on remand, and some told us that the lack of an adequate bail address was the reason they were remanded to Ashley Youth Detention Centre.

All victim-survivors described being subjected to sexual, physical and other abuse by staff at the Centre or older detainees, or both. We summarise themes in the accounts of alleged abuse by staff below, including in relation to sexual abuse (including through personal searches) and the humiliation and belittling of children and young people. In Case study 3, we closely examine isolation practices at Ashley Youth Detention Centre, including individual accounts of this practice. In Case study 4, we summarise individual accounts of the use of force by staff towards children and young people in the Centre.

Some victim-survivors told us they were forced to share a unit with, or were left unsupervised in the company of, older boys detained at the Centre, despite some pleading with staff that they were not safe. They were subsequently sexually abused, sometimes by groups of older boys. We summarise the accounts of harmful sexual behaviours in Case study 2.

It is incomprehensible to us that children were exposed to such abuse while in the care of the State.

Most of the victim-survivors whose accounts we have reported told us they had experienced trauma before being detained, which contributed to their contact with the justice system and may have made them more vulnerable to sexual abuse once in detention. We heard that victim-survivors came from unsettled, tumultuous and broken family situations. One young person was living in a shelter before her detention at Ashley Youth Detention Centre; another was homeless and two were in out of home care.<sup>680</sup> Victim-survivors spoke of physical abuse in their familial settings and of mental health issues that were triggered or exacerbated by their traumatic circumstances. It makes no sense to us that children and young people living under these pressures were not assessed for, and provided with, support services, rather than being detained, especially in circumstances where they had not been said to have committed an offence. In Chapter 9 of our volume on out of home care and in Chapter 12 of this volume, we discuss the need to support, and advocate for, at-risk children, and to ensure detention is imposed as a last resort.

Many victim-survivors told us that their abuse by staff, or their subjection to the harmful sexual behaviours of other detainees, began as soon as they were admitted to Ashley Youth Detention Centre. As described by Ben, Simon and Erin, when young people first arrived at the Centre, they would undergo an admission process that could involve a period of isolation ranging from a few hours to a week.<sup>681</sup> We were told by Ben and another former detainee whose account is not recorded here that, in addition to the inherently humiliating experience of being strip searched and isolated, there was also a practice of applying scabies cream to young people's naked bodies, causing a burning

sensation.<sup>682</sup> We understand that this practice occurred from the mid to late 1980s until the early 2000s.<sup>683</sup> A staff member described the practice in a statement he made in 2020 to the Department:

The kids would come in, they would be showered and they would be de-liced ... and you would have to paint their bodies with scabies cream ... The process involved painting just about every inch of their body, including genitals ... The cream would get applied with a paintbrush. Most of the time staff would apply most of it, including to the genital area ...<sup>684</sup>

We received evidence from another former detainee of Ashley Youth Detention Centre that, when he was first admitted to the Centre at the age of 13 in the late 1990s, it was midnight, and he was strip searched and ‘painted head to toe in anti-scabies lotion’ in what he referred to as ‘punishment on top of punishment’.<sup>685</sup> He also described a further incident involving the application of scabies cream as follows:

Once, they said there was an outbreak of scabies, so they line[d] us all up and they painted us all again. The stuff gets left on you, till 3.00 pm the next day when you can shower. It stung, and it’s genital torture. It wasn’t diagnosed by a doctor, it wasn’t completed by a nurse, just a staff member.<sup>686</sup>

Centre staff using strip searches as a tool of control, and as an opportunity to sexually abuse children and young people, was a common theme across the accounts of victim-survivors. We heard that victim-survivors were subjected to aggressive and ‘harrowing’ strip searches on numerous occasions during their time at Ashley Youth Detention Centre.<sup>687</sup> The mother of one victim-survivor told us that her son asked her to stop visiting him in detention because of the strip searches he had to endure before and after her visits.<sup>688</sup> As a result, her son was further isolated from the support he needed.

Others described being restrained while strip searched, and several victim-survivors detailed being sexually assaulted during ‘cavity’ searches, including through digital penetration. We also received evidence of male guards performing cavity searches on female detainees by inserting their fingers into detainees’ vaginas.<sup>689</sup> Erin described how she was regularly strip searched by male staff members and never provided the option to be searched by female staff.<sup>690</sup>

Some victim-survivors described being stripped naked by staff, verbally abused and left in locked rooms for extended periods as punishment for any number of actual or perceived infractions.

Many, if not all, of these accounts of strip searches are allegations of child sexual abuse by staff.

Female victim-survivors described staff targeting them for humiliation. For example, Charlotte described staff trying to see down her top, making comments about her body and touching her inappropriately.<sup>691</sup> Erin recounted that staff controlled her access to basic amenities such as a bra and sanitary products.<sup>692</sup>



We are particularly concerned by reports that female detainees, who were often alone or in the minority among male detainees at Ashley Youth Detention Centre (and thus especially vulnerable while in detention), said they were targeted for sexual harassment and abuse arising from their gender. We also heard that older boys would harm younger boys.

Several victim-survivors told us that sexual abuse by Centre staff was often perpetrated off site or in areas of the Centre that did not have closed-circuit television, so the abuse was less likely to be detected. Victim-survivors further recalled that if they attempted to avoid off site ‘excursions’, they were met with reprisals, including having food withheld.<sup>693</sup>

We were told that staff provided children with cigarettes and other privileges, such as more television time, if they submitted to abuse, both on- and off-premises.<sup>694</sup> We heard that this level of manipulation has had lifelong adverse effects on victim-survivors’ understanding of their sexuality, their intimate relationships and their capacity to trust, because they believed that accepting such incentives meant they accepted the abuse.<sup>695</sup>

Victim-survivors who spoke to our Commission of Inquiry described being subjected to many forms of humiliating, belittling and threatening conduct at Ashley Youth Detention Centre. We heard evidence that being the target of staff members’ derogatory language and verbal threats often happened in conjunction with admission processes, strip searches, isolation and during the perpetration of physical and sexual abuse on Centre premises and off site. Many of the incidents described to us are likely to constitute human rights abuses under instruments such as the United Nations Convention on the Rights of the Child.

One common way that young people described being humiliated and sexually violated at the Centre was being watched by staff while they were showering. Showers at the Centre were visible through observation panels, which were designed so staff could open the panel and check the location and wellbeing of young people, especially if they were at risk of suicide or self-harm.<sup>696</sup> Young people told us that this design was abused.<sup>697</sup>

We also received accounts of young people having insufficient access to toilet facilities while in isolation, including being given only a bucket to use or otherwise being forced to urinate and defecate on their cell floor.<sup>698</sup> The Department told us that none of the rooms at Ashley Youth Detention Centre had toilets until refurbishments in the early 2000s.<sup>699</sup> The Department advised that when a toilet was otherwise unavailable, access to toilet facilities occurred at the request of a detainee while they were in isolation.<sup>700</sup>

Alysha (a pseudonym), former Clinical Practice Consultant, Ashley Youth Detention Centre, told us that, during her employment at Ashley Youth Detention Centre between late 2019 and mid-2020, staff made direct threats of physical violence against detainees.<sup>701</sup> She described a staff member threatening to turn a young person ‘into



an owl' if they did not change their behaviour. She recalled being told that this meant the staff member would 'cave the child's face in'.<sup>702</sup> We also received evidence from Alysha of young people being teased about their weight and called names such as 'fat fuck' by staff while being strip searched.<sup>703</sup>

If this conduct did occur, it involves using degrading language to demean the young person and to frighten them as a means of securing their compliance and exercising power and control. The *Youth Justice Act 1997* prohibits any form of psychological pressure intended to intimidate or humiliate children and young people in detention, as well as any form of physical or emotional abuse, or any kind of discriminatory treatment.<sup>704</sup> Young people in detention are entitled to, and deserve, humane treatment and the maintenance of their dignity. Every child has the right not to be humiliated, belittled or threatened.<sup>705</sup>

The sense of utter helplessness that anything could be done about the ways in which young people were treated in detention was palpable across the accounts by victim-survivors, who commonly stated that, after initial attempts to report abuse, things often got worse rather than better for them. Therefore, they learned never to complain again. Victim-survivors told us that reprisals for reporting the abuse included severe violence from staff and other detainees. Consequently, some young people stopped disclosing sexual and physical abuse to other staff members, their parents, community visitors and statutory authorities, such as the Commissioner for Children and Young People.

We are deeply saddened to report that one of the most common themes to emerge from the accounts we have documented was the devastating ongoing trauma that the abuse at Ashley Youth Detention Centre has had on victim-survivors' mental and physical health. We heard that many victim-survivors have attempted suicide, struggle with significant mental health conditions and addictions to drugs and alcohol, and have been incarcerated during their adult lives.

Ben provided a particularly evocative reflection on how the violent sexual abuse that he told us he experienced at Ashley Youth Detention Centre eventually broke him, and his realisation that using violence himself was the only way to survive.<sup>706</sup> His account provides just one illustration of the failure of Ashley Youth Detention Centre to fulfil a core purpose of youth justice—rehabilitation. Instead, through a culture of humiliation, denigration, control, violence and abuse, Ashley Youth Detention Centre seems to have contributed to the antithesis of rehabilitation—further criminalising young people.

Many of the victim-survivors and their family members told us what they wanted to see happen at Ashley Youth Detention Centre and in relation to the youth justice system more broadly. Most commonly, they said they want proper mental health and other supports—not remand—for children when they start offending, and for the Government to reduce its reliance on detaining children and young people overall. They also told us that they want:

- an acknowledgment from the Government about what has happened to them
- a prohibition on staff who have abused children in detention from ever working with children again
- comprehensive background checks on anyone seeking employment at a youth justice facility
- a rehabilitative facility for young people that is more centrally located and ensures detainees have access to a full education
- closed-circuit television throughout a new facility
- female and male young people to be housed separately in detention facilities, with girls to be supervised only by female staff
- a safe and effective process for children to make complaints about their treatment when detained
- more cultural support for Aboriginal young people in detention.

## 4 Management recognition of the scale of the abuse

Despite a large number of claims and allegations filtering through various redress programs and civil claims, we heard it was only relatively recently that the full scale of allegations—and that many allegations were against current staff—became apparent to senior managers in the Department.

It started to become generally understood in the Department in late 2020 that many of the allegations through redress programs and schemes, civil claims and other sources related to current staff at Ashley Youth Detention Centre. We discuss this development in more detail in Case study 7.

Although he knew about the existence of the Abuse in State Care Program from 2014, Secretary Pervan told us it was in late 2020 that he became aware a significant number of current Ashley Youth Detention Centre staff were named in those records and other redress claims:<sup>707</sup>

There was a lot of activity in a very short period of time. It would have been towards the end of 2020 where we became aware of the extent of the number of current employees who were implicated from the various redress programs ... and the severity of the allegations.<sup>708</sup>

A former Acting Executive Director, People and Culture in the then Department of Communities, explained to us that the ‘true picture ... as to what may have occurred at Ashley’ only came to be understood at the time that various pieces of information (from civil claims, National Redress Scheme applications and Abuse in State Care Program applications) were put together and viewed as a whole.<sup>709</sup>

We were told that when reviewing this information together, it became clear there was a pattern of alleged abuse occurring at Ashley Youth Detention Centre over a lengthy period, and that many allegations related to current employees.<sup>710</sup> At hearings, the former Acting Executive Director, People and Culture described her realisation of the extent of the allegations of abuse around August or September 2020 (soon after she joined the Department) once the various sources of information were viewed in totality:

Probably up until that point [the point at which she viewed the totality of claims together] I’d only read a few applications, maybe one or two letters of demand, but when you have, I believe, in excess of 300 applications that have come through detailing acts of abuse, and you can see the same names and the same types of abuse, and you can pick up themes and— it’s quite confronting.

...

... there is probably too much commonality in some of the methods of abuse, if I may call it that, or the allegations; that, for people that have spanned so many different years, to not believe that they’re— it’s not a matter of belief, but some of the themes have just repeated so much that it does definitely cause a lot of concern, and I think I’ve been quite specific in my statement as to a couple of those areas where I think that we see themes coming through now in terms of almost opportunities for abuse when they occurred, such as strip searches; that’s probably the main one coming through.

...

But you do have, again, these themes that just continue and again going back to the strip searching one, and it’s just how it’s described in these applications ... a lot of the people didn’t even see what happened to them in terms of a cavity search as being a sexual abuse; it was almost like it was an intimidation tactic, and that’s how they describe it in their applications, and some of them are so detailed that they are very concerning.<sup>711</sup>

Mandy Clarke, former Deputy Secretary, Children, Youth and Families in the then Department of Communities (between September 2019 to February 2022), told us she was alerted to the possibility of a history of claims made relating to serving staff after a meeting she had with an external lawyer on 31 August 2020 that prompted her (and others) to begin to cross-check records against serving staff.<sup>712</sup> In her statement to us, Ms Clarke said she was shocked and confronted by the allegations and never anticipated that the Department would need to respond to so many historical allegations of abuse involving current employees.<sup>713</sup>

Under questioning at hearings, Pamela Honan, Director, Strategic Youth Services in the then Department of Communities, conceded that there were abusive patterns of behaviour exhibited by Centre staff towards detainees.

Q [Counsel Assisting]: ... [W]ould you accept from the materials that you've reviewed that it's been a place where children have been physically abused? Not all children, but quite a lot?

A [Ms Honan]: There's— absolutely, yep.

Q: That there's been an ongoing pattern of what I would call emotional abuse or disregard in the way in which children have been treated by at least some workers?

A: Yes.

Q: And would you also accept that there's clearly been an ongoing pattern of sexual abuse of some residents by some workers?

A: I would agree.<sup>714</sup>

Ms Honan also conceded ongoing problems with harmful sexual behaviours being displayed by detainees against other detainees.<sup>715</sup>

Secretary Pervan also accepted Counsel Assisting's proposition that it is open to our Inquiry to find that there has been an ongoing pattern of sexual abuse of some detainees by some staff members over the past 20 years.<sup>716</sup> At hearings, Secretary Pervan conceded this in response to questioning by Counsel Assisting:

Q [Counsel Assisting]: ... [W]ould you agree that, having regard to all of the evidence that's available, it's open to the Commission to find that there has been ongoing sexual abuse of some detainees by some officials at Ashley over the last 20 years?

A [Secretary Pervan]: Yes, I would.

Q: And that, whether we describe it as a 'pattern' or 'repeated conduct' or whatever, nevertheless it's clear that it's not isolated incidents; would you accept that?

A: Yes.<sup>717</sup>

Stuart Watson, Manager, Custodial Youth Justice ('Centre Manager'), acknowledged that Ashley Youth Detention Centre had a 'dark past'.<sup>718</sup> He noted it was not for him to draw conclusions about the truthfulness of some allegations made against staff but acknowledged that his reference to a 'dark past' necessarily involved wrongdoing by staff towards detainees.<sup>719</sup>

We note that, in recent times, as discussed in Case Study 7, the Department has conducted some misconduct investigations in response to allegations of abuse at Ashley Youth Detention Centre. However, the Department did not take disciplinary action in respect of the Abuse in State Care Program allegations until late 2020 at the earliest and, in some cases, much later (and only after other allegations had been

raised against staff members). As a result of the time span over which allegations were made against some staff, we can only conclude that some alleged abusers continued to work at the Centre for many years after allegations were first made against them and, as a consequence, had access and opportunity to continue to abuse children and young people in detention during this time.

## 5 The broader context

The allegations of abuse need to be understood in context, including a longstanding corrosive staff culture, the beliefs of some staff that children and young people in Ashley Youth Detention Centre sometimes or often deserved punishment and make false allegations, and the fact that the Centre is isolated, physically and operationally from the department that oversees its.

### 5.1 A longstanding corrosive staff culture

It is clear to us that a significant proportion of staff members have worked at Ashley Youth Detention Centre for many years. Victim-survivor Erin, who was at the Centre in the mid to late 2010s and whose experiences we have outlined above, told us that she encountered staff who had worked at the Centre for 30 years.<sup>720</sup> Staff members Ira, Lester and Stan (all pseudonyms), against whom a number of serious complaints of abuse were made (discussed in Case study 7), all began work when the Centre was the Ashley Home for Boys.<sup>721</sup>

In a May 2016 Minute to the Secretary, it was noted that many staff had been working at the Centre for more than 15 years.<sup>722</sup>

Ms Clarke confirmed that a large cohort of the Centre's total staff have worked at the Centre for a very long time and that such staff continually describing 'the old days' could make it challenging for Centre management to redefine the culture in line with a more therapeutic approach.<sup>723</sup> She reflected on this further in hearings, adding:

... some staff that perhaps dominated decision making that had been there for some time, and that perhaps new staff who brought fresh ideas and new ideas and new way of thinking, their thoughts were not always reflective in that decision; in fact, sometimes they just weren't even being heard ...<sup>724</sup>

Information provided in the accounts of victim-survivors, as well as evidence from others, further suggests that the personal connections of staff members at Ashley Youth Detention Centre, beyond their common employment, meant that staff 'looked after each other' and that it was challenging for individual staff members to raise concerns about the misconduct of their colleagues.<sup>725</sup>

A participant in one of our sessions with a Commissioner, who asked to remain anonymous, told us that:

Most of the staff [at Ashley Youth Detention Centre] were farmhands from around the Deloraine area. Nobody had qualifications. There was a bit of a joke: if you're a member of [a particular club], you've got a job at Ashley. They were all connected through the ... club.<sup>726</sup>

Ben, who was first detained at the Centre in the early 2000s, similarly stated that when he was at Ashley Youth Detention Centre it was 'run' by a group of families who would employ other family members and their friends to work there.<sup>727</sup> When he was released from detention, Ben recalled seeing a photo at a club in the local area and could identify more than 50 per cent of the club members in the photo as people connected to Ashley Youth Detention Centre.<sup>728</sup>

As documented throughout this case study, we heard evidence from multiple sources about staff members working together to manipulate, control and abuse children. Warren, who was at the Centre for various periods between 2004 and 2009, described being raped on numerous occasions by different staff members while other staff restrained him and subjected him to verbal abuse.<sup>729</sup> Erin recounted to us that male staff members watched as she was sexually abused by a group of older male detainees.<sup>730</sup> Otis, who was admitted to the Centre in the early 2010s, referred to staff as having a 'gang mentality'.<sup>731</sup> Fred, who was first detained at the Centre in the early 2000s, told us that staff treated violence between young people in detention 'like a sport', either provoking violence or encouraging it when it broke out, rather than stepping in to de-escalate a situation.<sup>732</sup> Max described multiple occasions where a number of staff physically or sexually abused him.<sup>733</sup>

Otis, who told us that he began to 'offer' himself to staff members when he realised that they were targeting younger children to abuse, suggested that sexual abuse at Ashley Youth Detention Centre was not uncommon, at least during the early 2010s when Otis was detained there.<sup>734</sup> We were also told of staff withholding essential medication unless young people submitted to sexual acts, despite repeated requests by young people to staff that they needed this medication.<sup>735</sup> Several accounts allege that physical and sexual abuse was perpetrated by two or more staff acting together. Some victim-survivors stated that other staff saw or heard physical and sexual abuse take place. There were multiple accounts of children's attempts to make reports to staff.

There were also striking similarities in some of the ways that victim-survivors told us they were abused at Ashley Youth Detention Centre, with accounts naming multiple staff over decades using the same tactics, such as abuses perpetrated under the guise of strip searching.

In a submission to our Commission of Inquiry, Ms Sdrinis, who represents more than 300 victims of abuse seeking compensation from the Tasmanian Government

(150 of whom relate to Ashley Youth Detention Centre), raised concerns about ‘collusion’ among staff at Ashley Youth Detention Centre.<sup>736</sup>

Numerous clients have described a sense of collusion between staff at [Ashley Youth Detention Centre] that inhibited reporting of abuse. Clients report there were numerous husband/wife teams working as guards ... gang members working as security, and security personnel referring friends for shifts at [the Centre].

This created a perceived sense of solidarity between the guards, and an ‘us vs them’ attitude for staff and residents. This combination of circumstances allowed perpetrators to continue offending for many years, effectively unchecked.<sup>737</sup>

Alysha, who reported allegations against a staff member, Lester, in January 2020 (discussed in Case study 7), told us that:

Due to the, at times, nepotistic recruitment practices and Tasmania being a small place, speaking up often carries additional considerations such as being friends, community members or parents of children at the same school as someone acting inappropriately. With the Centre being in such a remote location, this issue is additionally compounded as the majority of the staff group live in a small town together. Not only is there fear of professional consequences such as failing to be considered for promotions or being bullied at work, but there are also social considerations that would leave staff ostracized or possibly in danger of reprisal in their own community.<sup>738</sup>

It is further apparent from the accounts of victim-survivors and their families that some new staff were drawn into a culture of degrading children and young people detained at the Centre or ignored the abuse happening around them. While we heard that some staff members who witnessed abuse made attempts to report it, we also heard that some new staff who may have ‘started off well’ would ‘turn into the same as the other ones’.<sup>739</sup>

Ben told us that:

The hardest thing for me to accept about this abuse is that all of the other staff that weren’t doing it to us had to have known. There were times when we did get to leave Ashley to go places and do fun things, but there was always a process. We would have to fill out paperwork. The times we were abused there was no process. We were just told that we were going fishing or caving or something like that, and then just taken off site.<sup>740</sup>

He also told us that staff who did not want to take part in the abuse were sidelined for ‘not toeing the line’. He said that these staff, who could have made a difference, were ‘continually pushed out’.<sup>741</sup>

In a panel at hearings, Professor Donald Palmer and Dr Michael Guerzoni—both experts in organisational misconduct—described how an organisation’s dynamics can foster such indoctrination. Dr Guerzoni, who teaches in the field of criminology (including youth justice), has examined many of the reports into Ashley Youth Detention Centre.<sup>742</sup>



Dr Guerzoni spoke of formal and informal aspects to the socialisation of staff, describing informal components including:

... the so-called water cooler conversations, lunchtime conversations, barbecue chats and that kind of thing where informal tips on how to do the job or ways of seeing problems and situations which arise within an organisational setting and how to respond to those.<sup>743</sup>

Dr Guerzoni further reflected:

... it is my understanding that the evidence suggests that new workers at Ashley Youth Detention Centre have been socialised into a punitive culture that is informed by a view that the children in their care are bad people who do not deserve to be treated well.<sup>744</sup>

Dr Guerzoni went on to note that even though Ashley Youth Detention Centre has introduced a range of policies and procedures designed to improve safety, the desired change does not seem to have achieved the intended effect.<sup>745</sup>

Speaking more broadly about cultures within youth detention settings, Professor Palmer said:

People who become guards in a detention facility very quickly learn from their peers what the culture of that organisation is and it may be; for example, never trust a child and what they say. That might not have been a view that they held before they took the job as a guard in a juvenile detention facility.<sup>746</sup>

Samantha Cromptvoets, a sociologist who has examined misconduct in the armed forces, described risks of negative socialisation and misconduct in 'closed' organisations or those that are 'in isolated parts of a network' where distinct norms and behaviours can emerge among a group:

... when you enter an organisation, you take cues from everyone around you regarding ... what is normal and what is not. Part of this is the natural human desire to conform and assimilate. So for organisations or parts of organisations that are closed, it is important that there are checks and balances in place to prevent new employees conforming to the behaviours of the rest of the group.<sup>747</sup>

It seems unlikely that persistent incidents of abuse like this could have happened without some level of staff awareness or collaboration. It also seems unlikely that abuse of this nature and to this extent could have occurred without some other staff knowing about it, or at least harbouring concerns or suspicions.

## 5.2 A culture of disbelieving detainee complaints

In addition to the broader culture that we heard worked to dehumanise children and young people, we observed a view held by many staff, management and even some external agencies that detainees were sometimes or often unreliable witnesses and concocted false allegations of abuse for monetary gain or retribution against staff.

A youth worker at the Centre, Sarah Spencer, said that she had observed some detainees make statements about their intentions to falsify complaints for redress purposes:

The government gave these young people, ex-residents whether they went to Risdon, payouts when they said, 'Oh, so and so interfered with me or did this'. No investigation, just gave them 10 grand there, 20 grand there, 30 grand there. We knew about it because they told us all the time. They would leave the Centre saying, 'I'm going to say this when I leave, so and so got this much money for saying this'. Constantly we've lost valuable workers through a lot of unproven allegations with no investigations whatsoever.

...

It just doesn't make— it's horrific, because they just kept handing them money with no investigation, and now we've got this flood of allegations, and there would be a percentage, I'm not diminishing that, but all of these false allegations take away from the legitimate ones.<sup>748</sup>

Ms Spencer also told us that she believed all young people who reported abuse to her and appropriately escalated all reports of abuse she received.<sup>749</sup>

Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, told us that staffing levels at the Centre were affected in part by 'the perception of threats from young people about the making of false claims against staff'.<sup>750</sup> In our public hearings, she said:

Q [Counsel Assisting]: Do you mean that people are worried that they'll be falsely accused of physical or sexual abuse?

A [Ms Atkins]: Some young people have actually voiced that they will say, you know, 'You touched me' or whatever, so that they can get a payout. I have heard that.

Q: And it's your assumption that, if a young person said that, it wouldn't be truthful?

A: Not when they're smiling and laughing in front of me, no.<sup>751</sup>

Mr Watson agreed with Counsel Assisting's proposition that 'a lot of staff' would hold the view that many allegations made by detainees are false.<sup>752</sup> Mr Watson pointed to one factor leading him to this conclusion about such a view among staff:

Often these people have worked with each other for a long period of time, and I guess, you know, it is the example of, do you really know your neighbour and do you really know what they do?<sup>753</sup>

In reflecting on his opinion of the views of staff later in oral evidence, Mr Watson felt there would likely be mixed views among staff about detainee accusations of abuse, with some thinking that suspensions of staff because of some of these complaints were ‘timely’.<sup>754</sup>

Former detainees Max and Warren shared with us that staff told them that reporting abuses was futile because no one would believe them.<sup>755</sup> Otis disclosed some of his abuse to a psychologist at the Centre and told us that he was not believed.<sup>756</sup>

Both the Commissioner for Children and Young People, Leanne McLean, and the Ombudsman, Richard Connock, agreed with Counsel Assisting’s proposition that many young people may not have reported their abuse to oversight bodies partly due to fear of not being believed.<sup>757</sup> Mark Morrissey, a former Commissioner for Children and Young People, told us he believed children at the Centre did not have confidence that their reports or concerns would be adequately responded to.<sup>758</sup>

The abuse of children at the Centre became normalised—so much so that some young people at the Centre understood the violence and abuse by staff against them as ‘normal’ treatment.<sup>759</sup>

We received evidence to suggest that this scepticism of detainee complaints was not confined to the Centre and Department, but also extended to some external agencies. In Case study 7, we discuss attitudes inside Tasmania Police that were dismissive of allegations of abuse at Ashley Youth Detention Centre.<sup>760</sup>

As we have made clear, it was not possible for our Commission of Inquiry to test the veracity of accounts given to us by detainees or to determine the prevalence of any false complaints. We do consider, given the patterns and consistency in allegations over decades, that at least a proportion of these allegations are likely to have occurred. We consider the prevailing views and attitudes of Centre staff, and bodies tasked with protecting children at the Centre, to be relevant to understanding how longstanding and systematic abuses at the Centre were not identified and addressed.

### 5.3 Isolation of Ashley Youth Detention Centre

It is clear to us that the risk of abuse at Ashley Youth Detention Centre (and the likelihood that it would go unchecked and unreported) was heightened, in part, due to the physical isolation of the Centre, and because of breakdowns in communication and leadership between those working at the site and those in the Department. Ms Honan described her immediate impression of the Centre when she began her role in October 2019:

[The Centre] operated independently to the broader Division of Children, Youth and Family Services (CFS) and Department of Communities. It was highly autonomous, inward facing and lacked strategic leadership. My impression was that there was

also a high degree of mistrust and selectivity in what and how information was reported by the Manager up to the executive to ensure the operating of the centre was positively regarded. The relationship with independent statutory bodies appeared to be wary and uncooperative.<sup>761</sup>

At hearings, Ms Honan elaborated on the relationship between the Centre's management and the broader Department, telling us that the Centre operated as a 'satellite' and that it was 'very closed, very wary, and very defensive'.<sup>762</sup> She told us: 'I think what I was being told, but then what I was hearing and seeing on site suggested something quite different'.<sup>763</sup> She also observed that the relationship had 'changed significantly' since 2020 due to many factors, including her weekly physical presence at the Centre and the 'functional alignment' of certain positions that are physically based at the Centre but are also 'professionally supported and interface outside the centre'.<sup>764</sup>

Ms Clarke agreed with Ms Honan's observations that the Centre was operating in a closed environment without a clear passageway to the executive when she began working at the Department in 2019.<sup>765</sup>

In response to questioning at hearings, Secretary Pervan also agreed that the Centre was disconnected from the broader Department and characterised by an insular and inward-looking culture.<sup>766</sup> When we asked him about the cause of the Centre's self-isolation from the rest of the Department, Secretary Pervan said:

I think it's a broader reflection of cultural norms and history in that there's been a facility on that farm—and Ashley does sit on the edge of a farm that's owned by the Crown—for around 100 years. It was like a lot of our not-good past, a shameful past you might say, that no regard was given to young people ...<sup>767</sup>

Secretary Pervan reflected on his role as Secretary and the role of the executive in allowing the self-isolation of the Centre to occur:

Q [Counsel Assisting]: Doesn't that reflect on the management above Ashley in the hierarchy up to and including you if, if up to 2019 the Ashley management had been permitted to isolate themselves and not participate properly as part of the Department?

A [Secretary Pervan]: There is a reflection there, I'll own that; I was also running the Tasmanian Health System, so it wasn't as if I wasn't aware of the issues at Ashley, and I very much depended on a succession of Deputy Secretaries to be informing me, as I was those conversations with the Commissioner for Children and Young People as to what was happening at Ashley and what I needed to do to remedy it ...

It was very difficult to find out exactly what the situation was at Ashley other than noting that it was a facility that was isolated and had isolated itself over a considerable period of time. As with the Deputy Secretary and Director level, there was a succession of Centre managers, and getting to grips with not only what was the problem but what we could actually do about it was incredibly challenging.

Q: And so the practical effect of that ... was that it appears that over a series of years the self-isolation of Ashley from the scrutiny that might be best practice in terms of an open line of communication up through the Director of Custodial Justice and up through the Deputy Secretary to you, that was able to continue so that it was still in place in October 2019?

A: Yes.<sup>768</sup>

It is clear from the Department's evidence that senior members of the Department were aware of the inadequate scrutiny and supervision that occurred due to the Centre's physical location and a culture in which it could self-isolate from the broader Department. We consider this evidence is relevant in understanding how abuses at the Centre continued over a long period without adequate responses from the Department.

## 6 Observations

Children and young people were supposedly sent to Ashley Youth Detention Centre for rehabilitation from the complex factors that contributed to their offending. In doing so, they entered a highly controlled environment that was largely closed off from the community. They become wholly dependent on staff to care for them, meet their basic needs and protect them from harm. The experiences victim-survivors shared with us paint a harrowing and heartbreaking picture of systematic mistreatment over years—mistreatment that included physical abuse, sexual abuse, verbal abuse, denigration, humiliation, bullying, threats, intimidation, use of isolation and other likely human rights abuses.

While we acknowledge the evidence we received from some staff about the propensity of detainees to falsify claims (or at least state an intention to do so), we can only say that the accounts that we heard from current and former detainees were consistent in terms of the individuals and patterns they described over different periods and varied in ways that suggest a lack of collusion between detainees. Their accounts often were measured and nuanced—particularly in recognising the existence of staff who were not complicit in the behaviour and who recognised their plight for what it was. Many of their accounts, particularly around the culture and dynamics at the Centre, echo the recollections of staff, former staff, some senior managers and oversight agencies. Taken together, all the descriptions of Ashley Youth Detention Centre reveal a toxic and callous environment—a very far stretch from a therapeutic place of rehabilitation and recovery.

## **Finding—For decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse**

Considering all the evidence from victim-survivors and their families, current and former Centre staff, senior management in the Department, the many prior reports and investigations into the Centre, the allegations made through civil and redress scheme claims, the matters considered in Case study 7, and the insight of relevant experts into organisational misconduct, we consider that many children and young people were systematically dehumanised, brutalised and degraded while at Ashley Youth Detention Centre. We do not accept that the mistreatment of detainees occurred only as rare or isolated incidents, or that it always occurred in a highly concealed fashion. We consider it reflected a widespread and, at times, methodical practice, albeit to varying degrees. In this sense, the abuse, including sexual abuse, was systematic.

The broader dynamics at Ashley Youth Detention Centre contributed to a perfect storm that enabled abuses, including sexual abuse, to be perpetrated over a long period. We consider there are complex and varied motivations among staff who harmed children, or who contributed to or ignored harms. We consider at least some staff members were motivated abusers with an abiding sexual interest in children and young people, while other staff members were opportunistic in their abuses, and others again perpetrated abuse as a means of exerting power and dominance over detainees. We also consider it likely some staff felt peer pressure to conform to the poor practices of others (for example, when performing strip searches) and participated reluctantly on this basis, but also to avoid becoming targets for abusive or bullying behaviour from colleagues. We consider some of this behaviour reflects a highly traumatised and dysfunctional workforce.

We accept that not all staff engaged in problematic practices, but we consider many would have been aware of the poor treatment of detainees. As discussed in Chapter 3, cognitive biases (such as wilful blindness) may have contributed to such staff minimising the nature and scale of the behaviour occurring around them, alongside the gradual normalisation of such callous brutality, which operated to erode normal human reactions. Also, a sense that reporting the conduct would be futile—or worse, place them at risk in some way—may have contributed to inaction or people simply leaving their roles.

We acknowledge that some staff did seek to investigate and report abuses, and to escalate such alleged abuses to their superiors, despite feeling discouraged from doing so.

We consider a range of factors are relevant to the culture that enabled systematic abuse of detainees, which includes the following:

- As discussed in Chapter 10, the highly pressured, stressful and occasionally frightening conditions in which staff sometimes had to work, coupled with inadequate professional training and development for some staff, made it more likely for staff to deviate from best practice when seeking to manage the behaviour of detainees. We also consider it likely that difficult—and at times violent—behaviours exhibited by detainees contributed to staff holding negative attitudes towards them.
- Familial and personal connections between some staff created strong social disincentives to challenge, question or report poor behaviour of staff towards detainees.
- The often-longstanding tenure of staff contributed to entrenching problematic attitudes and normalising the poor treatment of detainees. New starters were socialised into this environment, and efforts to promote change towards therapeutic approaches were resisted.
- Staff (and broader community) attitudes that diminished the humanity and credibility of detainees worked to reduce empathy and compassion for them; it heightened scepticism of any complaints or concerns they may have raised in the Centre and beyond.
- While they felt violated, detainees were not always aware that abusive practices likely contravened law, policy or human rights conventions.
- Detainees were disinclined to speak out about abuses for reasons including the stigma and a lack of confidence in reporting processes, the normalisation of their mistreatment and genuine fears for their safety and the safety of their families.

We also consider that the broader context of Ashley Youth Detention Centre contributed to this abuse going unidentified and unaddressed. The physical isolation of the Centre and the culture in which it operated as a ‘satellite’ from the broader Department enabled conditions in which abuse could be perpetrated and not reported, resulting in delays in action from the Department and an unacceptable level of risk to children. The closed nature of Ashley Youth Detention Centre—and the vulnerability of detainees at the Centre—made it especially necessary for the Department to maintain close supervision over the Centre. Instead, the inadequate scrutiny and apparent inability to address the cultural and physical conditions in which a closed environment was able to flourish meant that inherent risks went unchecked by the executive and abuse could continue.



# Case study 2: Harmful sexual behaviours

## 1 Overview

Over the course of our Commission of Inquiry, we heard from many victim-survivors about their exposure to and experiences of harmful sexual behaviours, often by older male detainees, at Ashley Youth Detention Centre. In this case study, we summarise allegations of harmful sexual behaviours over many years at the Centre. We also consider the Centre's and the Department's responses to these allegations. We recount allegations that staff sometimes actively used the fear of harmful behaviours of children and young people to control other children.

We outline detainees' personal accounts of experiencing harmful sexual behaviours, drawing from the accounts we present in Case study 1. We then focus on a series of incidents involving three young people, Max, Henry and Ray (all pseudonyms), between 2018 and 2022.<sup>769</sup> First, we outline the law and policies during this period. Then, we provide a timeline of incidents involving these three young people. The timeline begins when Max was first admitted to Ashley Youth Detention Centre. It follows the responses of the Centre and the Department to some of the harmful behaviours, including harmful sexual behaviours, of young people in Tasmania's youth justice system.

Throughout this discussion, we highlight specific and systemic failings in the management of Max, Henry and Ray—as well as the children and young people who were displaying harmful sexual behaviours. At the end of the timeline, we highlight some of the systemic problems that were common to the incidents, including:

- staff tensions
- an absence of risk assessments
- a lack of capacity to respond to complex behaviours of children and young people
- the importance of critical incident investigatory skills.

We are particularly concerned about the disrespect and disregard apparently shown to staff who endeavoured to raise or address the risks to young people at Ashley Youth Detention Centre. We received information about unprofessional conduct, silencing in meetings and written complaints being ignored or deflected. We are concerned about apparent efforts to undermine the status and expertise of those professionals raising concerns.

This chapter covers a series of concerning allegations regarding the responses of Ashley Youth Detention Centre staff to harmful sexual behaviours displayed by some young people at the Centre. We acknowledge there have been and are staff at Ashley Youth Detention Centre who have sought to do their jobs lawfully and appropriately. References to ‘staff’ in this case study are not intended as a reference to all staff at Ashley Youth Detention Centre, unless explicitly stated in a specific context.

In the final section of this case study, we provide our general observations about systemic and operational deficiencies at Ashley Youth Detention Centre, which we consider have contributed to young people being exposed to or experiencing sexual harm by other detainees.

We identify that, over many years, some staff had knowledge of the harmful behaviour, including harmful sexual behaviour, of children and young people against other children. There was often an inadequate response to the risk that such behaviour could occur, as well as inadequate responses when it did occur. Children and young people in detention have too often been exposed to serious harm, including sexual harm, by other children and young people in detention. Some staff have not taken enough steps to protect them.

## 2 What we heard from victim-survivors about harmful sexual behaviours

In Case study 1, we outline personal accounts of young people’s allegations of harmful sexual behaviours at Ashley Youth Detention Centre, including the following:

- In the early 2000s, 11-year-old Ben (a pseudonym) told us he was placed with much older boys who physically and sexually abused him on numerous occasions during his first admission.<sup>770</sup> He had multiple admissions to Ashley Youth Detention Centre and said he was frequently sexually abused by older boys.<sup>771</sup> He said his abuse occurred in the Centre and on outings, where there was less supervision.<sup>772</sup> He told us that, when he told staff early on about the abuse, they essentially blamed him for putting himself in such a position.<sup>773</sup> At other times, he said he was punished for speaking up.<sup>774</sup>
- Charlotte (a pseudonym) told us she was sexually abused by boys at Ashley Youth Detention Centre on several occasions in the mid-2000s when she was in her mid-teens.<sup>775</sup> She told us staff were aware she had a history of experiencing sexual abuse, but she was left alone with groups of boys and was sexually abused more than once.<sup>776</sup> She said she reported the abuse after leaving Ashley Youth Detention Centre but heard nothing more.<sup>777</sup>

- Fred (a pseudonym) told us he was in his late teens in the mid-2000s when he witnessed a detainee raping another boy and was himself physically abused by other boys at Ashley Youth Detention Centre.<sup>778</sup> He said he learned not to speak up because he experienced retribution from staff and residents.<sup>779</sup>
- Oscar (a pseudonym) told us he was in his mid-teens when he was first admitted to Ashley Youth Detention Centre in the middle of the 2000s.<sup>780</sup> He said older boys sexually abused him within days of his admission while a staff member watched on and laughed.<sup>781</sup> He said other boys regularly physically abused him but did not disclose for fear of being labelled ‘a snitch’.<sup>782</sup>
- Erin (a pseudonym) first came to Ashley Youth Detention Centre in the mid-2010s.<sup>783</sup> She told us she was left unsupervised with a group of 10 boys, where she was sexually abused.<sup>784</sup> After disclosing the abuse, she said she did not receive any support.<sup>785</sup> Instead, she said she felt shunned by staff who had been reprimanded for allowing it to occur, and was subsequently and targeted and sexually abused by other boys.<sup>786</sup> She said staff witnessed the harmful sexual behaviours and did nothing but put her on the contraceptive pill.<sup>787</sup>
- In the late 2010s, Max was repeatedly placed in units with older boys who posed a risk of harmful sexual behaviours.<sup>788</sup> Consequently, he told us he was physically abused on numerous occasions, threatened with sexual abuse and then sexually abused with a table tennis bat.<sup>789</sup> He said his behaviour became more challenging as he sought to protect himself from other residents and he displayed harmful sexual behaviours himself.<sup>790</sup> Professional services staff came into conflict with operational staff about responding to incidents and protecting Max from harm.<sup>791</sup> We discuss Max’s account in more detail in the next section.

As we have made clear, it was not possible for our Commission of Inquiry to test the veracity of all the individual allegations outlined in victim-survivors’ accounts. However, we were struck by the many common themes across these accounts. While we do not make findings in relation to any individual allegation, we note the similarities across accounts.

In many of these accounts, younger children were placed with older children who had previously displayed harmful sexual behaviours and received no therapeutic intervention.<sup>792</sup> Although girls were generally placed in separate units from boys, the harmful sexual behaviours they told us about occurred when they were left unsupervised and outnumbered by boys in the Centre.<sup>793</sup>

Victim-survivors told us that some Centre staff were aware of incidents of harmful sexual behaviours but responded in ways that apparently condoned the behaviour—such as dismissing the damage caused by harmful sexual behaviours or responding passively or punishing children and young people for complaining about the harmful sexual behaviour of another child.<sup>794</sup> Victim-survivors told us these responses discouraged them from subsequently reporting harmful sexual behaviours they experienced or witnessed.<sup>795</sup>

# 3 The exposure to harm of vulnerable children and young people in detention, 2018–22

In this section, we focus on the specific experiences of Max, Henry and Ray from 2018 to 2022. We outline Ashley Youth Detention Centre’s response to these young people’s vulnerabilities to harmful sexual behaviours (and other harmful behaviours by young people) at the Centre.

Max, Henry and Ray have much in common. Each was detained at Ashley Youth Detention Centre in the past five years and some of their time there overlapped. Each of these three young people were particularly vulnerable to harmful behaviours from other detainees because of their age, experiences of trauma, mental health problems or more than one of these vulnerabilities. At some point during their detention, Max, Henry and Ray were housed in the Centre’s Franklin Unit despite protests from several staff and the young people themselves that this unit was not safe for them. All three young people were put at risk of or experienced harmful sexual behaviours by one or both of two detainees in the Franklin Unit, Albert and Finn (both pseudonyms).<sup>796</sup> It is our view that Ashley Youth Detention Centre failed to protect Max, Henry and Ray from harmful behaviours, including harmful sexual behaviours, of other young people. We discuss non-sexual harmful behaviours in this case study because harmful sexual behaviours can be one part of a spectrum of harmful behaviours.

We discuss other experiences that Max says he had in Ashley Youth Detention Centre elsewhere in this report (refer to Case study 1 and Case study 6). In this case study, we consider only those aspects of Max’s evidence, and the relevant evidence of others, that relate to his accounts of harmful sexual behaviours and the responses to those behaviours by Centre management and the Department.

First, we discuss the laws, policies and practices relevant to the 2018–22 period. We then outline several incidents of harmful sexual behaviours relevant to Max, Henry and Ray, as well as the varied responses of Centre staff to these incidents at the time.

## 3.1 The law, policies and practices

In this section, we provide some relevant context about:

- the laws and standards that prohibit bullying and physical and verbal abuse of children and young people in detention
- how decisions were made about where to place young people within Ashley Youth Detention Centre, including what we heard from former staff members about placing young people in the Franklin Unit

- the use of ‘Very Close Supervision’ orders at Ashley Youth Detention Centre to manage young people whose behaviour is considered a risk to others or to the security of the Centre
- how incidents involving harmful sexual behaviours are reported and investigated at the Centre.

### 3.1.1 Laws and standards

The *Youth Justice Act 1997* (‘Youth Justice Act’) prohibits using:

- any form of psychological pressure intended to ‘intimidate or humiliate’ a child or young person in detention
- any form of physical or emotional abuse
- discriminatory treatment.<sup>797</sup>

It also provides that a child or young person in detention is entitled to have their developmental needs met.<sup>798</sup> In addition, the *Inspection Standards for Youth Custodial Centres in Tasmania* includes several standards designed to protect vulnerable young people from verbal or physical abuse and bullying.<sup>799</sup>

### 3.1.2 Managing children and young people in detention through placement and supervision

#### Placement decisions

In Chapter 10, we detail how, prior to 31 May 2022, Ashley Youth Detention Centre staff decided the unit within which to place children and young people at the Centre.<sup>800</sup>

To summarise:

- The Centre Support Team generally made week-to-week placement decisions, although these could be changed daily, based on operational factors.<sup>801</sup>
- Placement decisions considered some or all the following factors:
  - age
  - gender
  - safety and security
  - legal status and length of sentence
  - individual needs
  - behavioural issues
  - relationship dynamics between young people and staff
  - the views of staff.<sup>802</sup>

- Due to operational challenges, including staffing numbers, placement decisions sometimes amounted to ‘choosing the best out of a poor range of options’.<sup>803</sup>
- Young people could make a formal request for a unit transfer, which the Centre Support Team would consider.<sup>804</sup>

## Franklin Unit

Until recently, the Franklin Unit was the most secure unit at Ashley Youth Detention Centre, housing ‘the most high risk or dangerous young offenders’.<sup>805</sup> Mr Watson told us that before the Centre’s redevelopment in 2022, the Franklin Unit was the only unit with a secure courtyard. It also had concrete (instead of plaster) ceilings.<sup>806</sup> He explained that certain children and young people in detention, such as those who presented an escape risk, were placed there.<sup>807</sup> Mr Watson told us that now all units at Ashley Youth Detention Centre have secure courtyards.<sup>808</sup> We understood his comments to mean Centre staff now have more flexibility in housing children and young people in detention who pose an escape risk.

Madeleine Gardiner, former Manager, Professional Services and Policy, Ashley Youth Detention Centre, recalled that, ‘on occasion’, youth workers or Centre Support Team members would comment that ‘placing certain detainees with other detainees was helpful to manage the behaviour of detainees’.<sup>809</sup> She told us the chair of the Centre Support Team said this was inappropriate and the ‘general consensus of the [Centre Support Team] would not support this’.<sup>810</sup> Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, believes young people were regularly placed in the Franklin Unit to ‘manage and punish behaviour that was considered disruptive by Operations staff’.<sup>811</sup> Her opinion is that staff relied on the reputation of the Franklin Unit and the fear of what happened to young people there ‘to essentially “scare them into line”’.<sup>812</sup>

Alysha believes the Franklin Unit was operated very differently from other units, specifically in terms of how it was staffed.<sup>813</sup> She said:

There were ‘Franklin staff’, whereas [staff in the other units] all seemed to rotate a little unless there was a particular issue for a staff member. None of the staff rotated as they ought to, but the Franklin staff appeared to dictate the rules under which they worked. They would ‘refuse’ to work in any other units.<sup>814</sup>

Alysha’s concern echoes matters departmental staff identified in a 2016 Minute to the Secretary with the subject line ‘AYDC–Commissioner for Children letter and emerging concerns’ (refer to Case study 3 for more detail).<sup>815</sup> This Minute noted serious concerns about human rights abuses and, among other things, that the Tasmanian Government had previously agreed ‘staff at Ashley Youth Detention Centre were to work across teams when requested to do so rather than working solely in the allocated smaller team groups’.<sup>816</sup> We note one of the recent reforms we discuss further in this case study (in response to the 7 August 2019 incident) was to regularly rotate staff through all units.<sup>817</sup>

We asked several past and present Ashley Youth Detention Centre staff about placing young people in the Franklin Unit. The general response was there was no policy or practice (informal or otherwise) of using some detainees as a threat to influence or punish the conduct of other children and young people in detention.<sup>818</sup> We were instead told placement decisions were made according to a range of factors such as age, individual needs and security.

### **Very Close Supervision**

We are aware it is sometimes necessary to place young people in units where staff anticipate incidents might occur.<sup>819</sup> In such situations, a Very Close Supervision order may be applied to the young person.<sup>820</sup>

In August 2019, *Standard Operating Procedure No. 8: Supervision and Movement of Young People* outlined the requirements for Very Close Supervision at Ashley Youth Detention Centre.<sup>821</sup> It stated:

Very Close Supervision (VCS) is used if a higher level of risk is presented by an individual young person.

Approval for a young person to be placed on and taken off VCS status can only be given by the Centre Support Team (CST), Operations Manager or On Call Manager based on information provided by operational and/or professional staff.

A young person may be classified as requiring VCS if it is assessed they are a serious safety and/or security risk due to:

- Aggressive, subversive and/or inappropriate behaviour.
- The risk of assault or harm from other young people.
- Escape or threat of escape.
- Any other reasons identified by staff that require a higher level of supervision.

The supervising Youth Worker will ensure the young person on VCS remains within five metres at all times whenever the young person is outside of a locked building.<sup>822</sup>

It is unclear from the wording of this Standard Operating Procedure whether a youth worker is required to be within a certain distance of the young person on Very Close Supervision while the young person is inside a building, or if the terms of the supervision only apply outside a locked building. We are aware that some young people have been placed under Very Close Supervision inside and outside a unit.<sup>823</sup>

The Department's Serious Events Review Team (described further in this case study and in Chapter 9) received evidence from a staff member that in practice, Very Close Supervision may not 'guarantee' that a young person would receive one-on-one supervision.<sup>824</sup> Rather, it was suggested that Very Close Supervision was considered more of an 'alert' to staff to be watchful for potential problems, as opposed to a direction



to increase supervision itself.<sup>825</sup> The review concluded that Very Close Supervision ‘is problematic and difficult to achieve’ even when in use, given the insufficient staffing numbers and the lack of understanding among Ashley Youth Detention Centre staff on how Very Close Supervision operates.<sup>826</sup>

As discussed in the timeline below, Ray was subject to a Very Close Supervision order during a period of his detention at Ashley Youth Detention Centre. However, it does not appear that Albert and Finn were placed on Very Close Supervision orders in response to the incidents outlined below, despite staff being aware of their ongoing sexualised behaviours towards younger detainees.

### 3.1.3 Incident reporting, referrals and review

#### Incident reporting, detention offences and conferences

Staff at Ashley Youth Detention Centre must record and report any incident arising from the behaviour of a young person or young people.<sup>827</sup> As discussed in Chapter 10, incident reporting at the Centre occurs in line with the *AYDC Incident Reporting Procedure* (‘Incident Reporting Procedure’) and the incident report template.<sup>828</sup>

The Incident Reporting Procedure came into effect on 1 July 2018.<sup>829</sup> We understand it is still used today.<sup>830</sup> We were told that staff receive incident reporting training during their induction and periodically during refresher training.<sup>831</sup>

The Incident Reporting Procedure states that the aims of incident reporting include to:

- record ‘thorough, accurate and objective information’ about an incident, including injuries
- provide ‘impartial and responsible assessment processes’ that ensure the seriousness of an incident is appropriately classified
- ‘encourage mutual accountability between young people and staff’ for their behaviours and actions
- support consistent decision making
- ensure incident reports are appropriately escalated through management, the Department’s executive and Minister, as required
- support ‘independent and external oversight of incident management’.<sup>832</sup>

As outlined in Chapter 10, the reporting staff member must also recommend a ‘level of seriousness’ for the incident for each young person involved against one of the following categories:

- recorded incident
- minor incident
- detention offence.

The Operations Coordinator must sign off on all incident reports, noting any alternative recommendations.<sup>833</sup> There is also a requirement for a 'Management Assessment', which involves the Centre Support Team considering:

- the level of seriousness of the incident
- identifying whether the police, Child Safety Services or a young person's parents should be notified
- whether any other actions, such as an independent investigation, should take place.<sup>834</sup>

Where an incident involves a detention offence or isolation, or the Centre Support Team cannot reach a decision in relation to the seriousness of the incident, the Centre Manager must then review the circumstances of the incident and complete the relevant parts of the Management Assessment, including considering whether any notifications or further actions are required.<sup>835</sup> The Director, Strategic Youth Services, must decide whether any independent investigation of an incident is required.<sup>836</sup>

Under section 140 of the Youth Justice Act, the Secretary must be notified of any detention offences that the offender admits committing. The Secretary must then confer with the offender and any other relevant person before determining how the offence should be dealt with. As outlined in Chapter 10, the Secretary may deal with the offence by:

- taking no action, 'on the undertaking of the offender to be of good behaviour for a period not exceeding 2 months'
- cautioning the offender
- delaying the offender's release from youth detention by no more than three days
- filing a complaint against the offender.<sup>837</sup>

We note that in March 2022, Michael Pervan, the then Secretary of the Department of Health and Human Services (and later the Department of Communities), delegated his functions for dealing with a detention offence to the holders of several other roles, including the:

- Deputy Secretary, Children, Youth and Families
- Director, Youth and Family Violence Services
- Ashley Youth Detention Centre Manager
- Ashley Youth Detention Centre Assistant Manager
- Operations Manager (to a more limited extent)
- Coordinator, Training and Admissions (to a more limited extent).<sup>838</sup>

While we have not received an exhaustive record of previous delegations of these functions, we note that similar delegations were in place (at least in practice) for many years before this.

The Youth Justice Act requires that a conference is held, where practicable, with a young person who has committed a detention offence.<sup>839</sup> *Standard Operating Procedure No. 24: Conferencing* describes conferencing as ‘an opportunity for both the offender and victim to enter a restorative discourse and for the offender to take responsibility for their behaviour and to make appropriate reparation’.<sup>840</sup> *Standard Operating Procedure No. 24* also provides that sanctions may result from a conference, such as a ‘good behaviour bond’.<sup>841</sup>

We understand that for a conference to be held, the offender must admit to the offence and agree to take part in the conference.<sup>842</sup> If possible, the conference should involve the victim, a support person, a guardian and appropriate staff representatives.<sup>843</sup>

As noted throughout the timeline and other sections in this case study, Centre management and staff allocated different levels of seriousness to the incidents involving Max, Henry, Ray, Albert and Finn. Despite detention offences being recorded against Albert and Finn, it is unclear whether conferencing took place.

### **Senior Quality and Practice Advisor**

In line with Ashley Youth Detention Centre’s *Referral to a Senior Quality and Practice Advisor Procedure*, clinical staff could seek the advice of a Senior Quality and Practice Advisor from the Department’s Children and Youth Services division after an incident had occurred and about managing the behaviours of a detainee.<sup>844</sup> As outlined in Chapter 9 in relation to out of home care, specialised Senior Quality and Practice Advisors, and the Quality Improvement and Workforce Development Team they were in, were abolished during the Strong Families, Safe Kids redesign, which began in 2019.<sup>845</sup> Secretary Pervan told us these roles were substantively replaced with new roles performing similar functions, with the Senior Quality and Practice Advisor functions substantively transitioning to the Senior Development Manager role.<sup>846</sup>

The purpose of making a referral to a Senior Quality and Practice Advisor was to ‘access an independent and impartial resource’ that would ‘provide guidance in relation to ethical considerations and practice, and provide objective, evidence-based recommendations’.<sup>847</sup>

The *Referral to a Senior Quality and Practice Advisor Procedure* required that:

- a referral was made by the Clinical Practice Support Officer or the Multi-Disciplinary Team
- the Multi-Disciplinary Team considered referring complex and critical cases to the Clinical Practice Support Officer in the first instance

- if the Multi-Disciplinary Team considered the matter to be unsuitable for referral to the Clinical Practice Support Officer (due to urgency, complexity or a requirement for independent investigation), the referral could be made to the Senior Quality and Practice Advisor
- the referral had to be endorsed by the Centre Manager
- the referral had to be approved by the Director, Strategic Youth Services.<sup>848</sup>

As we discuss later in this chapter, a referral was made to a Senior Quality and Practice Advisor after an incident involving Ray, Albert and Finn.

### **Serious Events Review Team**

The Serious Events Review Team mentioned throughout this part is:

... a small team of senior practitioners who undertake reviews when a child [or] young person ... known to Children and Youth Services (CYS) has experienced a serious event, such as death, serious injury or 'near miss'.<sup>849</sup>

As described in Chapter 9, Ginna Webster, former Deputy Secretary, Children and Families, Department of Health and Human Services, established the Serious Events Review Team in 2017.<sup>850</sup> We were told this team was established in consultation with then Secretary Pervan.<sup>851</sup>

It is our understanding the Serious Events Review Team was disbanded in May or June 2020, but can be brought together on an ad hoc basis if required (refer to discussion in Chapter 9).<sup>852</sup> The team's former manager explained that its reviews usually involved the following process:

- The Children and Families Executive referred a matter to the Serious Events Review Team for review, along with the terms of reference of the review.<sup>853</sup>
- A Serious Events Review Team reviewer would undertake a comprehensive review of the matter in line with the terms of reference.<sup>854</sup> Their review would include desktop analysis of all relevant data as well as interviews with relevant staff.<sup>855</sup>
- The reviewer would prepare a draft review report, which was provided to a 'Moderation Group' for discussion.<sup>856</sup> The Moderation Group comprised the Manager, Workforce Development; the Manager, Clinical Practice Consultants and Educators; and the Manager, Policy and Director Service Deployment.<sup>857</sup> The Moderation Group was intended to run 'fresh eyes' over all aspects of the report, including editing and analysis.<sup>858</sup>
- The final report would be provided to the Executive of the Department and the Serious Events Review Committee, which comprised representatives internal and external to the Department.<sup>859</sup>

- The Serious Events Review Committee would consider the report and prepare advice to the Secretary.<sup>860</sup>

The former manager also explained the team's role 'was complete upon delivery of the final review reports'.<sup>861</sup> The Children and Youth Services Executive was responsible for implementing any recommendations.<sup>862</sup>

## 3.2 Max, Henry and Ray

### Timeline of Responses to Harmful Sexual Behaviours at Ashley Youth Detention Centre, 2018–2022

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#### 3.2.1 Summary

Over an 18-month period in 2018 and 2019, there were at least six reported incidents where Albert or Finn had engaged in sexualised behaviours. These included:

- making sexualised comments
- discussing sexual activities with staff
- simulating sexual acts on other young people
- forcing residents to touch each other's genitals
- exposing their genitals and anus to other young people
- forcibly exposing the genitals and anus of other young people
- placing their hands down their pants in front of other young people.<sup>863</sup>

All but one of these incidents was recorded as a detention offence.<sup>864</sup> Max, Henry and Ray were all placed in the Franklin Unit with Albert or Finn at various times, exposing them to the risk of harm.

We received evidence that Finn's behaviours were serious enough to consider a transfer from Ashley Youth Detention Centre into the adult prison system. A transfer application was drafted in early 2019.<sup>865</sup> That application identified that Finn 'require[d] a high level of secure care because he represents a high risk to the security and safety of himself, other detainees, staff' and the Centre's operations.<sup>866</sup> The application noted 'numerous incidents of inappropriate sexual behaviour' with other residents and other instances of violence and intimidating behaviours while at the Centre.<sup>867</sup> The application also identified that Finn's mental health difficulties contributed to his risk of offending generally.<sup>868</sup> A report prepared by the Centre's psychologist (and included with the draft application) stated that Finn posed 'a High risk of future violence'.<sup>869</sup> The application acknowledged that the Centre did not have the resources to support Finn to address

## Timeline of Responses to Harmful Sexual Behaviours at Ashley Youth Detention Centre, 2018–2022

### 2018

Max is placed with older detainees and experiences harmful sexual behaviours

#### June

The Serious Events Review Team reviews harmful sexual behaviours experienced by Max

### 2019

#### August 6

Henry is placed in the Franklin Unit

#### August 7

Henry experiences harmful sexual behaviours

#### August 8

Staff at Ashley Youth Detention Centre become aware of harmful sexual behaviours Henry experienced

#### August 9

The Centre Support Team discusses the harmful sexual behaviours Henry experienced

#### August 10

Another incident report is lodged about the harmful sexual behaviours Henry experienced

#### August 12

The Centre Support Team discusses Albert's and Finn's harmful sexual behaviours

#### August 13

Staff voice their concerns to the Centre Manager about the management of Albert and Finn

#### August 14

The Centre Manager notifies the Director, Strategic Youth Services of the incident involving Henry

#### August 19

The Centre Support Team again discusses the behaviours of Albert and Finn

Max is placed in the Franklin Unit

#### August 21

Centre management responds to concerns over Max's placement in the Franklin Unit

#### August 22

A staff member reports the harmful sexual behaviours Henry experienced to Child Safety Services

The Ashley Youth Detention Centre psychologist recommends risk management of harmful sexual behaviours

#### August 23

The Centre Support Team again discusses the behaviours of Albert and Finn

#### September 9

The Secretary is briefed about the 7 August 2019 incident involving Henry

#### September 18

The Ashley Youth Detention Centre psychologist alerts the Centre Manager of Henry's exposure to a risk of harm

#### September

Ray is admitted to Ashley Youth Detention Centre

#### October 8

The Ashley Youth Detention Centre psychologist reports harmful sexual behaviours to the Commissioner for Children and Young People

#### November 13–14

The Ashley Youth Detention Centre psychologist raises more concerns with the Centre Manager about Albert and Finn

#### November 15

The Ashley Youth Detention Centre psychologist documents her concerns about Albert and Finn in a letter to the Centre Manager

#### Early December

Behaviour management programs are initiated for Albert and Finn

Staff continue to raise concerns about Albert and Finn

#### December 6

The Ashley Youth Detention Centre psychologist again reports harmful sexual behaviours to the Commissioner for Children and Young People

#### December 9–10

The Director, Strategic Youth Services, initiates a review into the 7 August 2019 incident involving Henry

#### Mid-December

The Serious Events Review Team investigates the 7 August 2019 incident

#### December

Ray is moved to the Franklin Unit

The Multi-Disciplinary Team raises concerns about Ray's transfer to the Franklin Unit

### 2020

#### January 2

An incident occurs involving Ray, Albert and Finn

#### January 3

The Centre Support Team discusses the incident involving Ray, Albert and Finn

A staff member meets with the Director, Strategic Youth Services to discuss concerns about Ashley Youth Detention Centre

#### January 5

Ray attempts to escape from Ashley Youth Detention Centre

#### January 6

The Centre Support Team discusses the incident involving Ray, Albert and Finn

#### January 6

A referral is prepared to engage a Senior Quality and Practice Advisor

#### January 7

A management plan is developed for Ray

#### January 8

The Centre Support Team again discusses the incident involving Ray, Albert and Finn

A staff member reports concerns about the response to harmful sexual behaviours to the Director, Strategic Youth Services

#### January

The Ashley Youth Detention Centre psychologist informs the Department of Health about the poor response to the behaviours of Albert and Finn

#### January 20

The Secretary is briefed on concerns regarding Ray

#### January 28

Ashley Youth Detention Centre engages a Senior Quality and Practice Advisor

#### March 19

The Serious Events Review Team reports its findings and recommendations about the 7 August 2019 incident involving Henry

#### May 20

The Commissioner for Children and Young People receives the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

### 2021

#### June

The Department responds to the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

#### Post June

Reforms are implemented in response to the Serious Events Review Team's report

#### Mid-2021

Ray displays harmful sexual behaviours

#### December

Max asks to be transferred from Ashley Youth Detention Centre to adult prison

### 2022

#### Early

Max asks to be transferred from adult prison back to Ashley Youth Detention Centre



his behaviours, such as access to full-time mental health specialists.<sup>870</sup> We are unaware if the application to transfer Finn was ever lodged. It appears that Finn stayed at Ashley Youth Detention Centre at least until mid-2020 (whether as one uninterrupted admission or on multiple admissions).<sup>871</sup> We discuss the appropriateness of sending young people to adult prison below in relation to Max, but note this detail here because it indicates the Centre was aware of Finn's behaviours.

Max was only 12 years old when he was first admitted to Ashley Youth Detention Centre in the late 2010s.<sup>872</sup> We note that we have received evidence, from Centre staff and Max himself, that Max's behaviour during his 'lengthy history at the centre' could be complex and challenging.<sup>873</sup> Ms Gardiner told us she considered the decision by other staff to place Max in 'a unit with two detainees who had been observed to use sexualised behaviour' may have been made on the basis that '[s]ome staff found [Max] difficult to manage, and I am aware some staff did not like [Max]'.<sup>874</sup> Alysha gave evidence that Max was 'one of the most disliked children by the staff group'.<sup>875</sup>

Max told us he believes the harmful behaviours he experienced when he was first detained at Ashley Youth Detention Centre have had a lasting impact on his behaviour. He said: 'The abuse and how much they could have stopped it but didn't, is the main thing that has caused my behaviour problems'.<sup>876</sup>

On 6 August 2019, Henry was placed in the Franklin Unit with Albert and Finn.<sup>877</sup> Although Henry was technically a few months older than both Albert and Finn, we understand he may have been vulnerable in other ways. We have seen evidence that some Ashley Youth Detention Centre staff expressed concerns about his ability to process and retain information and noted that he was '[e]asily influenced by negative peers'.<sup>878</sup>

Henry was housed with Albert and Finn despite their behaviours being known to managers and staff at the Centre and despite Henry's care plan stating that he was 'vulnerable when with older boys and unable to be safe', as well as identifying that Henry had been the victim of an earlier incident in the Franklin Unit.<sup>879</sup> The care plan further stated that Henry was 'not to reside with [Albert] or [Finn]'.<sup>880</sup> Staff later reported that Henry was placed in the Franklin Unit 'because [Albert] and [Finn] would keep him in line'.<sup>881</sup> On 8 August 2019, Henry requested that he 'move units please anywhere'.<sup>882</sup>

Ray was first admitted to Ashley Youth Detention Centre in the late 2010s.<sup>883</sup> Ray had an extensive history of serious mental illness.<sup>884</sup> We are aware of multiple incidents and concerns during Ray's time in the Centre. In this case study, we focus on Ray's first admission to the Centre because the harmful behaviour he experienced was similar to that of Max and Henry.

When Ray first arrived at Ashley Youth Detention Centre, the Centre's psychologist emailed Operations Management staff with critical information about Ray.<sup>885</sup>

The psychologist explained:



The stability of [Ray's] mental health and the effectiveness of his care and management will strongly depend on his sense of safety and mitigation of stress. Thus, it will be important not only to carefully consider his unit and program placement, but also as far as possible to limit changes to his unit and group placements. Whilst I understand the operational difficulties arising from managing a group of youth all with their own set of complex needs, [Ray is] at a high risk of harm to himself and others.<sup>886</sup>

The psychologist identified that Ray experienced cognitive difficulties, suicidal ideation, hypervigilance, verbal and physical aggression and a 'vulnerability to the influence of others'.<sup>887</sup> To assist Ray during his time at the Centre, the psychologist made several recommendations to Operations Management, which were noted on Ray's care plan.<sup>888</sup> These recommendations included that Ray should be assisted with simple visual checklists outlining his daily schedule, that activities should be broken down so he did not get overwhelmed, and that he responded well to praise for good behaviour and gentle redirection if he was exhibiting signs of distress.<sup>889</sup> The psychologist shared her view that Ray would be suited to placement with a particular young person, and that his interactions would need to be closely monitored because they may rapidly deteriorate.<sup>890</sup>

During his detention, Ray was involved in numerous incidents that involved violence from and against other young people. Some professional services staff at the Centre tried to stop Ray being placed in the Franklin Unit because they considered other young people in that unit posed a significant risk to Ray.<sup>891</sup> Despite this, Ray was placed in the Franklin Unit. After a violent altercation with Albert and Finn, Ray tried to escape from the Centre.<sup>892</sup>

In late 2019, the Centre's psychologist emailed the Centre Manager to advise of a young person in detention disclosing to her that staff had threatened to transfer him to the Franklin Unit, that he felt unsafe, and that he had stated that detainees get 'stood-over, abused and raped' in the Franklin Unit.<sup>893</sup> The identity of the young person who disclosed these concerns to the psychologist is not revealed in the documents, but those concerns related to Albert's and Finn's behaviours.<sup>894</sup>

### **3.2.2 2018—Max is placed with older detainees and experiences harmful sexual behaviours**

Max recounted to us that on his first admission to Ashley Youth Detention Centre he was placed in a unit with three older detainees, including Floyd (a pseudonym) and Ned (a pseudonym).<sup>895</sup> Max told us he warned staff that he would be abused if placed with those detainees, but he was placed in the unit anyway.<sup>896</sup> When the three detainees returned to the unit from the day's activities, Floyd threatened Max.<sup>897</sup>

Max said that once the single staff member supervising the unit walked away into an office, Floyd exposed his penis to Max and told him 'you're going to be sucking this'.<sup>898</sup>

When Max refused, Max told us that Ned began slapping him, at which point Max punched Ned.<sup>899</sup> Ned then began punching Max, knocking him to the ground, before jumping on his head.<sup>900</sup> Max recalled that the supervising staff member shouted at the detainees and called for assistance but otherwise did not intervene to stop the abuse until other staff arrived.<sup>901</sup>

After the abuse, Max recalled he was moved to another unit. But Max was still placed with two detainees who were older and bigger than him, and he recalled that he was bullied and physically and sexually abused further, with the older detainees hitting him and pinching his buttocks.<sup>902</sup> Max recalls that one of the detainees was Arlo (a pseudonym).<sup>903</sup> He could not recall the name of the other detainee, but we know from other evidence available to us, including a Serious Events Review Team report, that the other detainee in the unit with Max and Arlo was Albert.<sup>904</sup>

About a week after he was moved to that unit, Arlo and Albert confronted Max, at which time Max says Arlo sexually abused him with a table tennis bat.<sup>905</sup> We understand that Albert was also involved.<sup>906</sup> Max told us nothing was immediately done to keep him safe after that incident. He remained in the unit with Arlo until he was eventually moved to a different unit for unrelated reasons.<sup>907</sup> An incident report was prepared three days after the incident occurred, but it is not clear to us whether any staff were aware of the incident earlier than this because staff were outside the room responding to a request for help at the time it occurred.<sup>908</sup> The incident report states it was prepared based on CCTV footage. It is also unclear to us how staff became aware of the incident and the existence of the CCTV footage.<sup>909</sup>

On his next admission to Ashley Youth Detention Centre, Max was again placed in a unit with Floyd, the detainee who had sexually abused him previously:

Before I got taken to the unit, I asked the youth workers who I was going to be with. They told me that it was someone from the North West that I wouldn't know. When I got to the unit I saw that the other person was [Floyd]. [Floyd] was the only other resident in there. I dropped all of my stuff and lost my shit and started screaming 'what's going on here'. The staff called a code black and while they were trying to restrain me, I assaulted one of the staff members. I was saying to the staff 'why the fuck are you putting me back in here when he tried to rape me'. They said that I was exaggerating. They told me that if I didn't calm down I would be put in isolation. After I calmed down, they told me that there was nowhere else I could go so I'd have to stay with [Floyd] in Bronte west.<sup>910</sup>

While Max notes that Floyd apologised to him, Max was still scared and decided that he 'would do something that would get [him] moved from the unit'.<sup>911</sup> Max damaged the ceiling in his room and was moved to another unit.<sup>912</sup>

It is unclear to us how meaningfully Centre staff considered Max's concerns about his unit placement at the time of the previously mentioned incidents. However, we have received evidence that suggests the Multi-Disciplinary Team discussed

Max's relationship with Floyd as an issue relevant to his unit placement in August and September 2018 (after the Serious Events Review Team completed its review, referred to in the next section). At that time, the Multi-Disciplinary Team recommended that Max and Floyd not be placed in the same unit or program group, noting that Max's desire to move units was likely related to his interactions with Floyd and that Max 'does not operate well when housed with' Floyd.<sup>913</sup>

### 3.2.3 June 2018—The Serious Events Review Team reviews harmful sexual behaviours experienced by Max

The Serious Events Review Team carried out a review into the two instances of harmful sexual behaviours Max experienced. This review was prompted by notifications from Child Safety Services in March and April 2018 following a report from Max's solicitor to Tasmania Police alleging that Ned had sexually abused Max at Ashley Youth Detention Centre.<sup>914</sup> The Serious Events Review Team's report covered the incident involving Floyd and Ned, as well as the incident involving Arlo and Albert.

In relation to the incident involving Floyd and Ned, the Serious Events Review Team investigated it as the 'alleged "rape" of [Max] by [Ned]' because the incident was notified to police in those terms by Max's solicitor.<sup>915</sup> The Serious Events Review Team broadly found that no rape or sexual abuse had occurred.<sup>916</sup>

The Serious Events Review Team's report stated that Max told the investigator that Ned commanded Max to perform oral sex on him before Ned physically abused Max.<sup>917</sup> We note that this is slightly inconsistent with Max's evidence to us that it was Floyd who gave this command while exposing his penis to Max before Ned hit Max. Regardless, the report contained no detailed analysis of the sexualised behaviour and abuse experienced by Max, instead focusing on whether the notified allegation of a rape was substantiated. Indeed, Max's experience of harmful sexual behaviour was met with no significant comment from the investigator other than the finding that 'no sexual assault of [Max] by [Ned] has occurred at [Ashley Youth Detention Centre] on the information available'.<sup>918</sup> We note that the Serious Events Review Team report did not mention Floyd's involvement.<sup>919</sup>

The Serious Events Review Team's report notes that the material the investigator reviewed 'shows a response to the incident as consistent with the current [Centre] procedures', including providing medical care for Max, conversations with Max encouraging him to report the matter to police, involving Max's parents and conferencing with Ned once Max declined to make a formal complaint.<sup>920</sup>

Regarding the incident involving Arlo and Albert, the Serious Events Review Team found a significant issue in the original incident report. The incident report, which was written with reference to the CCTV footage of the incident, stated the following:

- Supervising staff left the three young people unsupervised in the unit after staff attended to a code black emergency in another part of the Centre.

- Arlo and Albert then harassed and abused Max, with Albert jumping on Max's back and making sexually suggestive motions.
- Albert pulled Max's pants down before Max pulled them back up.
- Albert continued to intimidate Max, approaching him with his hand down his pants.
- Arlo removed his erect penis from his pants and encouraged Max to touch it, which Max did.
- Max was obviously upset and appeared to be crying.
- Arlo and Albert made comforting gestures to Max before staff returned to the unit.<sup>921</sup>

The incident report recorded that Arlo and Albert had both perpetrated abuse. Both were 'conferenced' in relation to 'inappropriate sexual behaviour', which meant they were required to meet and discuss the nature and impact of their actions with Centre staff.<sup>922</sup>

The investigator reviewed the CCTV footage as part of preparing the Serious Events Review Team report, finding the following:

- The footage showed staff leaving the young people unsupervised in the unit, Albert jumping on Max's back, Arlo and Albert harassing Max and Albert seemingly comforting Max when he became upset.
- The footage did not show Albert making sexually suggestive motions while on Max's back or Arlo removing his erect penis from his pants, but rather appeared to show him with a table tennis bat in his hand throughout the incident.<sup>923</sup>

The report noted that Arlo had 'accepted full responsibility for the incident' but denied the characterisation of the incident during conferencing, stating that it was a table tennis bat in his hand rather than his penis, and that this was consistent with the investigator's review of the CCTV footage.<sup>924</sup> This was also consistent with Max's characterisation of the incident to the investigator when Max was interviewed, as well as his evidence to us, in that Arlo attempted to sexually abuse him with a 'ping pong bat'.<sup>925</sup> The report also noted Albert 'agreed to having committed the offence' as part of the conferencing process.<sup>926</sup>

The Serious Events Review Team found that neither Arlo nor Albert perpetrated a sexual abuse based on the information available to the investigator:

In conclusion, the CCTV footage of the incident does not clearly portray sexual motions by [Albert], nor does it clearly show the exposure of a penis by [Arlo]. [Max] now states that [Arlo] had a table tennis bat in his hand. This was also the claim made by [Arlo] during the Conferencing process. There is insufficient information to substantiate sexual assault based on the information available at this point in time.<sup>927</sup>

The investigator acknowledged the incident involving Albert and Arlo was ‘likely to be intimidating and frightening for [Max]’, but otherwise made no significant findings beyond the factual occurrence and characterisation of the incident.<sup>928</sup>

The limitations of the review were noted in the following comment from the investigator:

... [a] review of records at [Ashley Youth Detention Centre] found multiple Incident Records referencing ‘Inappropriate Sexual Behaviour’ involving youth detainees other than the three residents referenced in this Review. By nature of being a youth detention centre and the known pathway to offending behaviour resulting in detention, the residents of [Ashley Youth Detention Centre] are majority male, adolescent and are likely to have dysfunctional backgrounds including exposure to family violence, poor parenting, poor school attendance, interface with child protection services and general trauma history. The result of this can be poor social skills, impulsivity and skills in understanding the impact of behaviour on others. These factors can result in behaviours in a detention centre that are far from ideal within the community, but must be managed on a daily basis within a detention centre setting.<sup>929</sup>

The investigator went on to comment that:

It is outside the scope of [the Serious Events Review Team] to provide recommendations as to the response of [Ashley Youth Detention Centre] to such behaviours both at a Centre and individual resident level. However, it may be useful to consider expert review, advice and on-going consultation concerning this issue to support [the Centre] to assist residents to develop socially appropriate behaviours for transition to the community.<sup>930</sup>

The Serious Events Review Team’s report also stated that Centre management had ‘openly acknowledged the action of both Youth Workers leaving the residents unsupervised in the unit was in breach of procedure’ and the staff members involved had also acknowledged the error and its role in the incident occurring.<sup>931</sup> Aside from the lack of staff supervision, the report noted that staff and management at the Centre ‘appear to have responded to this incident in a manner consistent with their procedures’.<sup>932</sup>

The report further noted that Max later raised concerns about being in a unit with Arlo and that the records reviewed showed ‘professional discussion and debate about this’ at the Centre.<sup>933</sup> Minutes of a Centre Support Team meeting dated shortly after the incident involving Arlo and Albert and attached to the Serious Events Review Team’s report indicated that Max was upset by the incident but did not want to move units at that time.<sup>934</sup> The minutes suggested staff were responding to Arlo and Albert’s harmful sexual behaviours and that Max would be offered counselling with the psychologist.<sup>935</sup>

Based on the evidence we received, we are concerned that Max was the victim of harmful sexual behaviours in the incident involving Albert and Arlo. Penetration, or attempted penetration, with a table tennis bat is a serious instance of harmful sexual behaviour. The Serious Events Review Team’s conclusion that because

‘sexually suggestive motions’ were not clearly visible on CCTV meant that harmful sexual behaviours did not occur is not, in our view, a sound one, particularly given the relevant incident report and the accounts from the young people involved supported a conclusion that harmful sexual behaviours involving a table tennis bat had occurred.

The choice of units in which Max was placed, in the context of his victimisation and subjection to harmful sexual behaviours by other young people in detention, continued to be an issue at the Centre for more than 12 months after the incident with Arlo and Albert. In this chapter, we further discuss Max’s subsequent subjection to other harmful sexual behaviours while detained in the Franklin Unit.

### **3.2.4 6 August 2019—Henry is placed in the Franklin Unit**

On 6 August 2019, Henry was placed in the Franklin Unit with Albert and Finn.<sup>936</sup> As previously outlined, this was despite a care plan for Henry stating that he was ‘not to reside with [Albert] or [Finn]’, that Henry was not safe being housed with older boys and that Henry had been the victim of an earlier incident in the Franklin Unit.<sup>937</sup>

There was a lack of evidence to explain why Henry was moved to the Franklin Unit. Documents later prepared by Centre Manager Stuart Watson stated that no risk assessment or Centre Support Team process appeared to have taken place before or after Henry was moved to the Franklin Unit.<sup>938</sup> Whatever the reason for the move, Pamela Honan, Director, Strategic Youth Services, acknowledged in her evidence that ‘the decision to place [Henry] into [the Franklin] unit was not properly considered or risk assessed’.<sup>939</sup>

### **3.2.5 7 August 2019—Henry experiences harmful sexual behaviours**

On 7 August 2019, an incident occurred involving Albert, Finn and Henry. We have reviewed the CCTV footage of this incident, which does not contain audio.<sup>940</sup> The CCTV footage shows Henry seated in a common room in the Franklin Unit with Albert, Finn and another resident, Jonathan (a pseudonym).<sup>941</sup> Henry was approached by Finn and Albert, who pulled Henry to the ground. During the incident, Finn and Albert pulled Henry’s pants down, exposing Henry’s buttocks and then Albert held a bottle near Henry’s exposed buttocks. After the incident, Albert and Finn left the room and Henry pulled his pants back up and retied the drawstrings. The incident lasted for approximately 20 seconds and staff members were not present. Jonathan remained in the room throughout the incident.



## **Finding—In August 2019, Henry (a pseudonym) was exposed to an unacceptable risk of harm and experienced preventable harm at Ashley Youth Detention Centre**

Henry was placed in the Franklin Unit despite a care plan for Henry stating that he was ‘not to reside with [Albert] or [Finn]’, that Henry was not safe being housed with older boys and that Henry had been the victim of an earlier incident in the Franklin Unit.<sup>942</sup>

The behaviours Finn and Albert expressed towards Henry were non-mutual or non-consensual sexual behaviours involving force and fall within accepted definitions of harmful sexual behaviours. Albert and Finn’s harmful sexual behaviours towards Henry were preventable.

### **3.2.6 8 August 2019—Staff at Ashley Youth Detention Centre become aware of harmful sexual behaviours Henry experienced**

It appears staff were first alerted to the 7 August 2019 incident the following day when Finn, Albert and another young person at the Centre, Frank (a pseudonym), joked about an attempted rape of Henry with a water bottle.<sup>943</sup> That conversation was not documented until 10 August 2019 (the relevant incident report is described in the next section). Staff identified the incident as likely having occurred on 7 August 2019 and that the matter should be notified to the Operations Coordinator at the Centre, Maude (a pseudonym).<sup>944</sup>

On 8 August 2019, Albert and Finn were involved in other incidents in the Franklin Unit in which they made sexualised gestures and appeared to try to engage other young people in sexualised acts.

On 8 August 2019, Henry asked that he ‘move units please anywhere’.<sup>945</sup> A staff member documented at that time that ‘staff are keeping a close eye on interactions between the new residents and the three Franklin residents’ and that Henry was ‘very uncomfortable and a bit nervous’.<sup>946</sup>

### **3.2.7 9 August 2019—The Centre Support Team discusses the harmful sexual behaviours Henry experienced**

The first documented report about the 7 August 2019 incident was lodged on 9 August 2019. That report recorded that a staff member had heard Finn and Albert telling other residents: ‘[Henry] is a bitch, he won’t even come out of his room, we fucked him with a water bottle. He was resisting until we got his pants down’.<sup>947</sup>

An Interim Centre Support Team meeting took place on 9 August 2019. The minutes of this meeting stated:



Franklin staff noticed [Henry] removing himself from the general population and upon conversation with [Henry] he advised that during his time in Franklin he has been receiving unwanted attention from [Albert] and [Finn]. Footage for the times suggested in the conversation have been reviewed but this shows more attention towards [Jonathan] than to [Henry] as [Henry] is not present.<sup>948</sup>

The Centre Support Team determined that Henry and Jonathan should be immediately moved from the Franklin Unit and asked if they would like their parents notified.<sup>949</sup>

The minutes also noted that more information about behaviour and comments staff had heard or seen needed to be recorded before the next Centre Support Team meeting.<sup>950</sup>

Also on 9 August 2019, the Operations Coordinator, Maude, viewed the CCTV footage of the 7 August 2019 incident.<sup>951</sup> Maude included the following description of the CCTV footage in another incident report relating to Albert, which she lodged on the same day:<sup>952</sup>

[Finn] walks toward [Henry] with [Albert] following. Both boys then grab [Henry] by the legs and pull him off his chair. [Henry] holding on firmly to his track pants, fights against [Finn] & [Albert] trying to pull his trackpants down. [Henry] ends up on his side. [Albert] reaches for the drink bottle and in a swooping manner brings it towards [Henry]’s buttocks. Both [Finn] & [Albert] quickly stand up and move towards the TV room entrance. [Henry] stands up and is seen to be pulling his track pants up which were clearly sitting below his buttocks at the back. During the ordeal it appears [Henry] holds onto the front of his trackpants. [Finn] has his back to the camera and is bent over the top of [Henry]. [Albert]’s face is [noticeable] to the camera and he is also bent over the top of [Henry].<sup>953</sup>

The incident report notes that the behaviour was not unusual or out of character for Albert.<sup>954</sup> We were not provided with a copy of any corresponding incident report specific to Finn or Henry.

Maude recommended the incident be recorded as a detention offence for Albert and Finn.<sup>955</sup> It is unclear whether Maude’s viewing of the CCTV footage or completion of the incident report occurred before or after the Centre Support Team meeting on 9 August 2019.

### **3.2.8 10 August 2019—Another incident report is lodged about the harmful sexual behaviours Henry experienced**

An incident report was lodged on 10 August 2019 about the conversation between Albert, Finn and Frank that staff overheard on 8 August 2019.<sup>956</sup> The report noted the following:

- Albert said Henry had ‘put himself in his room because he was scared of being raped’ and Albert had told Henry that ‘he rapes little boys like him’.<sup>957</sup> When the staff member asked whether Albert was joking, Albert laughed and said, ‘well yeah obviously—but not really’.<sup>958</sup>

- Frank told Clive (a pseudonym), a youth worker, that Henry had locked himself in his room because ‘we tried to rape him’.<sup>959</sup> When asked whether he was joking around, Frank said: ‘No, we actually tried to’.<sup>960</sup> We note that Frank was not present at the incident on 7 August 2019.
- Finn, Albert and Frank were talking about ‘pulling someone’s pants down, a bottle and holding someone down’.<sup>961</sup>
- Finn repeatedly said: ‘I don’t want to go to prison for rape—I hope they do not check the cameras’.<sup>962</sup>
- Finn stated the incident occurred while one staff member was in the toilet and the other was playing cards with another young person.<sup>963</sup>
- Frank told Clive about another incident of sexual behaviour between young people, stating: ‘I told [Finn] that I’d give him a coke if he touched me on the dick and he did’. Finn and Albert confirmed the incident happened as Frank described.<sup>964</sup>
- ‘In general, the sexualised talk in Franklin has escalated beyond normal “teenage boy” talk’ since Henry and Jonathan were moved to the Franklin Unit.<sup>965</sup>
- Finn told the staff members present: ‘Can you please stop putting small boys with long hair in this unit, we have been locked up a long time and we take out our sexual frustrations on them’.<sup>966</sup>

We are not aware of the reason for the two day delay in lodging this incident report.

### 3.2.9 12 August 2019—The Centre Support Team discusses Albert’s and Finn’s harmful sexual behaviours

On 12 August 2019, the incident involving Albert and Finn on 7 August 2019, and the subsequent discussions between the young people in detention on 8 August 2019, were again discussed at a Centre Support Team meeting.

The minutes of this meeting stated that there would be ‘zero tolerance with this behaviour and talk’.<sup>967</sup> The Centre Support Team was of the view that the level of seriousness of Albert’s and Finn’s behaviour warranted a ‘detention offence’ for each of them.<sup>968</sup> It was recorded that conferences would be held with Albert and Finn and that neither would ‘progress further than orange [colour level under the behaviour management system] until they attend’.<sup>969</sup> Albert (originally on the yellow colour level) and Finn (originally on the green colour level) were put down to the orange colour level, indicating disapproval of their behaviour under the behaviour management system.<sup>970</sup> Under a section titled ‘Positive Words’ for each of Albert and Finn, it was commented that each ‘had [a] good week aside from their incident reports’.<sup>971</sup>

The minutes also recorded a discussion about Henry’s behaviour regarding an unrelated incident on 5 August 2019, but he was moved from the red colour level to the orange colour level and taken off being ‘unit bound’.<sup>972</sup> There is no record of the impact of the 7 August 2019 incident on Henry. The only reference to Henry being subjected to harmful sexual behaviours was that ‘[Henry] was moved back to Bronte [Unit] due to some standover behaviour that [Henry] was subject to in Franklin’.<sup>973</sup> We found the use of the phrase ‘standover behaviour’ surprising. We are concerned it may indicate a lack of appreciation of the seriousness of what occurred to Henry in the Franklin Unit, particularly because Operations Team staff had heard Finn and Albert talking about ‘raping’ Henry.<sup>974</sup>

The meeting minutes do not record any dissent in the decision to place Albert and Finn on the orange colour level.<sup>975</sup> Ms Gardiner recalled, however, that she was present at that meeting and had made recommendations that were not followed.<sup>976</sup> In our public hearings, Ms Gardiner told us she had disagreed with the decision to place Albert and Finn on the orange colour level, believing red was the most appropriate colour for this incident.<sup>977</sup> Ms Gardiner further stated that the rationale at the meeting for not placing Albert and Finn on red was because ‘they would drop their bundle and that would cause some behaviour problems’, creating difficulties for Centre management.<sup>978</sup>

On 12 August 2019, Patrick Ryan, then Centre Manager, prepared and distributed a document titled *AYDC Weekly Report*.<sup>979</sup> Referring to the 7 August 2019 incident, the report stated:

An incident involving sexualised behaviour in Franklin was considered on the 9 August 2019 and reconsidered at [the Centre Support Team meeting]. Appears to be silly behaviour but [detention offence] for conferencing.<sup>980</sup>

We don’t know who received this weekly report.

### **3.2.10 13 August 2019—Staff voice their concerns to the Centre Manager about the management of Albert and Finn**

On 13 August 2019, Ms Gardiner emailed Mr Ryan and some members of the Centre Support Team to reiterate her view that the Centre Support Team’s response to Albert and Finn’s behaviour was inappropriate. She voiced the following concerns:

- Moving Finn and Albert to the orange (not red) colour level was inconsistent with other Centre Support Team decisions and did not appropriately reflect the nature and seriousness of the offending.<sup>981</sup>
- The rationale for moving Albert and Finn to the orange (not red) colour level was inappropriately influenced by concerns about Albert’s and Finn’s response to the colour level, and not on Henry’s wellbeing. Ms Gardiner criticised the rationale, which she identified as being that ‘on Red colour these two residents will “drop

their bundle” or similar’, that the Centre would struggle to manage Albert and Finn on red, and that Albert and Finn were long-term residents and would be experiencing some sexual frustration.<sup>982</sup>

- The Centre needed to notify Child Safety Services and the parents of the young people in detention, and to arrange support for all involved.<sup>983</sup> She reminded Mr Ryan and the Centre Support Team that ‘in the community this would be [considered] a level of abuse, and we are mandatory reporters’.<sup>984</sup>
- Staff were minimising Finn and Albert’s behaviour and needed training in relation to harmful sexual behaviours.<sup>985</sup>

On the same day, the Health and Community Services Union delegate emailed Mr Ryan on behalf of members to raise concerns about Centre Support Team decision making.<sup>986</sup> The email stated that ‘conferencing and a slap on the wrist will not be seen by either myself or [union] members as appropriate in this circumstance’.<sup>987</sup> The later Serious Events Review Team report stated that the delegate also noted there were inconsistencies in the Centre Support Team decision making, such as ‘awarding more severe consequences for physical assault than were awarded for sexual assault’.<sup>988</sup>

In his response to the delegate, Mr Ryan questioned why the members had approached the union and had not considered using internal mechanisms to address their concerns in the first instance.<sup>989</sup> We are unaware of the steps Mr Ryan took, if any, to address the union’s concerns.

### **3.2.11 14 August 2019—The Centre Manager notifies the Director, Strategic Youth Services of the incident involving Henry**

The Serious Events Review Team’s report regarding Henry dated 19 March 2020 recorded that, on 14 August 2019, Mr Ryan contacted Greg Brown, the then Director, Strategic Youth Services, via email to notify him of the incident and the differences in opinion among staff about the nature of the incident.<sup>990</sup> The email (as extracted in the report) stated:

I have viewed the footage, and I do not view it as a sexual assault. But the centre is full of armchair critics and some [youth workers] have gone to their [Health and Community Services Union] delegate who has put his two cents worth in.<sup>991</sup>

We discuss Mr Ryan’s description of the incident below.

Henry also had an appointment with the Centre’s psychologist on 14 August 2019, during which he revealed he was feeling threatened and had isolated himself in his room for safety.<sup>992</sup> After that appointment, Professional Services Team members noted that Henry was reluctant to talk about the incident, possibly due to fear of retribution.<sup>993</sup> There is no clinical record indicating Henry attended any more individual sessions with the psychologist before his release from the Centre a few months later, but he attended group work, including sessions concerning healthy relationships.<sup>994</sup>

Evidence indicates Henry was offered an opportunity to make a complaint to police but he declined to do so.<sup>995</sup> We do not know when that offer was made.

### 3.2.12 19 August 2019—The Centre Support Team again discusses the behaviours of Albert and Finn

Another Interim Centre Support Team meeting occurred on 19 August 2019.<sup>996</sup> The minutes of this meeting recorded that Albert and Finn were moved from orange to yellow colour under the behaviour management system.<sup>997</sup> The rationale for this change was not explained in the minutes, but the minutes do record that Finn had ‘quickly improved his behaviour following last week’s incidents’.<sup>998</sup>

The minutes recorded that the Centre’s psychologist ‘feels that there is a pattern of behaviour over more than a day with [Finn] & [Albert] that needs to be addressed’.<sup>999</sup> It was noted that the psychologist would continue to work with Albert, but that Finn did not engage with the psychologist.<sup>1000</sup> There was no suggestion of alternative therapeutic supports for Finn. The minutes also stated that ‘careful consideration’ was to be given to any unit or program placements with Finn and Albert, acknowledging the pair tended to ‘buddy up’ and display problematic behaviours.<sup>1001</sup>

The minutes of this meeting also suggested that Albert and Finn’s sexualised behaviour was affecting other young people in the Franklin Unit. The minutes record that Frank, who remained in the Franklin Unit with Albert and Finn, had been ‘intimidated by [others]’ behaviour in the unit, which may be why his comments around sexualised behaviour have increased’.<sup>1002</sup>

At this point, neither Albert nor Finn had attended a conference about the 7 August 2019 incident. The minutes acknowledged the need to prioritise conferencing in relation to the incident.<sup>1003</sup>

The Centre’s psychologist took her own notes from this meeting, which included the following observations:

Provided the members of the [Interim Centre Support Team] meeting with a summary of the incidents reviewed on the Franklin video footage. Raised concerns regarding: the seemingly organised nature of the intimidation behaviour; repeated sexualised behaviours including indecent exposure, sexualised harassment and bullying, assaultive behaviour with a threat/intimidation of sexual violence; and non-sexualised bullying/intimidation.<sup>1004</sup>

... Mr Ryan and [a staff member] disagreed with the seriousness of the incidents, describing the incidents as ‘horseplay’ and comparing them to behaviours observed in the community in various sporting teams. Furthermore, Mr Ryan, [a staff member] and [another staff member] appeared to affirm the risk management and the sanctions taken as proportionate to the nature of the incidents (CST meeting minutes 12/08/2019). However, [one staff member] conceded that should the victims involved in the incident have been female, the response to the incident would have been different, ‘would have unleashed a war’.<sup>1005</sup>

A further concern was raised that in the context of frequent and ongoing moves of residents between units the steps taken to ensure the immediate safety of the victims (i.e. moving them to another unit) may be insufficient to provide them with a perceived sense of and actual safety at [the Centre]. [One staff member] acknowledged the concerns, stating that selection of residents to be placed in a unit with either [Finn] or [Albert] would require special attention whereby younger and more vulnerable residents may be deemed to be at high risk of victimisation.<sup>1006</sup>

Mr Ryan denies describing the incidents as horseplay and comparing them to behaviours of sporting teams.<sup>1007</sup>

In the Ashley Youth Detention Centre Weekly Report, dated 19 August 2019, it was noted that:

... sexualised behaviour by some residents last week was re-visited this week. Residents have moved units as a practical response. CPR and case conferencing are also practical and theoretical responses.<sup>1008</sup>

The extent of any therapeutic intervention provided to Albert and Finn is unclear.<sup>1009</sup> We do not know the extent to which Albert continued to engage with the psychologist. We are also unaware of what other supports the Centre offered Finn after he declined to engage with the psychologist.

### **3.2.13 19 August 2019—Max is placed in the Franklin Unit**

On or around 19 August 2019, Max was transferred to the Franklin Unit. Max's placement in that unit raised concerns among the Centre's professional services staff. These concerns appear to have arisen because of the presence of other detainees in that unit, namely Albert and Finn. As noted, this was the second time Max had been placed in a unit with Albert, who had previously been involved in an allegation of an incident of harmful sexual behaviour directed at him.

Notably, Max's placement in the Franklin Unit with Albert and Finn occurred about two weeks after Albert and Finn had displayed harmful sexual behaviours towards Henry and at a time when the Centre's management and staff were still considering the seriousness of that incident.<sup>1010</sup>

It is unclear to us why Max was placed in the Franklin Unit. The Centre Support Team meeting minutes from the day the decision was made to transfer Max do not reflect any discussion about his placement in the Franklin Unit.<sup>1011</sup> Rather, those minutes state that Max was requesting a transfer and had been moved between different units (not Franklin) within the Centre.<sup>1012</sup> We infer from this that the decision to place Max in the Franklin Unit was made after that meeting, likely by Operations Team staff without the direct input or consideration of the Centre Support Team.<sup>1013</sup>

### 3.2.14 21 August 2019—Centre management responds to concerns over Max’s placement in the Franklin Unit

On 21 August 2019, Ms Gardiner emailed her concerns about Max’s placement in the Franklin Unit to Mr Ryan and the Operations Manager:

I am raising the serious risk to [Ashley Youth Detention Centre], [Max] and Franklin residents of the placement of [Max] in the Franklin unit with the current residents.

Recently there has been a number of incidents of serious sexually inappropriate behaviour from [Albert] and [Finn] to other residents.

[Max] has been the subject of [Serious Events Review Team] review of incidents where he has reported being sexually assaulted by other residents. One of these incidents was by [Albert].

This unit placement is very inappropriate. It places [Max] at risk of being exposed to further sexual incidents, which he already feels vulnerable to. As well as puts [Albert] and [Finn] in a position of risk of continuing this behaviour, as they have done this in the past.

The decision also put[s] [the Centre] at risk from a significantly concerning incident occurring regarding sexualised behaviour.

I cannot imagine [Max] would feel very safe in this unit – with one resident who has previously been the subject of sexually inappropriate behaviour towards him, and now he is with two residents for who there is evidence of sexually abusive behaviour.

I request this [unit] placement be [reviewed] asap to ensure the safety of residents.<sup>1014</sup>

In her statement to us, Ms Gardiner referred to the placement of Max in the Franklin Unit as an example of some operational staff failing to adequately consult other Centre staff about placements and making placement decisions outside the processes of the Centre Support Team.<sup>1015</sup>

In response to Ms Gardiner’s concerns about Max’s placement, the Operations Manager appears to have immediately recognised the risk and addressed the issue, transferring Max to another unit.<sup>1016</sup> In his response to Ms Gardiner, the Operations Manager also noted that the decision to place Max in the Franklin Unit had been made by other staff two days prior, while he was on leave.<sup>1017</sup>

Ms Gardiner told us she also raised concerns with Mr Ryan about the risk posed by Operations Team staff making placement decisions without proper consultation. Ms Gardiner stated that Mr Ryan’s response was that she should ‘read the “Unit Moves” policy’.<sup>1018</sup> Ms Gardiner said that, after reviewing that policy, she told Mr Ryan the policy, as applied in practice, placed young people at risk and needed to be reviewed.<sup>1019</sup>



Mr Ryan has provided us with his own file note of his initial conversation with Ms Gardiner, which records her objection to the placement decisions and processes.<sup>1020</sup> It also records Mr Ryan explaining that the levels of '[Operations Coordinator] and up can use' the relevant procedure to make unit placement decisions.<sup>1021</sup> Mr Ryan's note also records that:

[Ms Gardiner] suggested that staff need supervision, and to involve [Professional Services and Policy] in unit moves. I explained that an operational decision can be made, if it's based on operations. Thus any discussion on concerns go to the [Operations Coordinator] and/or [the Operations Manager].<sup>1022</sup>

We understood Mr Ryan's note to mean that some Operations Team staff could make decisions about unit moves if there was an operational reason to do so. An example of an operational reason for a unit move might be damage to unit infrastructure that required a young person to be moved to a different unit.

### **3.2.15 Observations—Placement decisions involving Max**

We were concerned by the evidence that Max was placed in the Franklin Unit with Albert and Finn only a matter of weeks after these two young people had engaged in harmful sexual behaviours against Henry, and at a time when Centre management and staff were still considering the seriousness of that incident. We note that before Max's placement in the Franklin Unit he had also been subjected to harmful sexual behaviours by Albert.

Ashley Youth Detention Centre was aware of concerns about Max's safety. As previously outlined, Ms Gardiner had raised concerns soon after the decision was made to place Max in the Franklin Unit, making clear her disagreement with the decision considering Max's vulnerability, the previous behaviour of Albert towards Max and the harmful sexual behaviours engaged in by Albert and Finn. A few days later, Ms Gardiner raised her concerns about Operations Team staff making placement decisions without proper consultation. We are concerned that operational matters were prioritised over protecting young people from the risk of harmful sexual behaviours.

While Max was ultimately placed in a different unit without incident, it appears that no Centre-wide steps were taken to ensure that Max or other vulnerable young people would not be placed in a unit with detainees who were known to engage in harmful sexual behaviours. There should be an integrated, consistent and trauma-informed approach to unit placements in youth detention.

Ms Gardiner's diligence in identifying risks and advocating for Max's safety is to be commended.

## **Finding—In August 2019, Max (a pseudonym) was exposed to an unacceptable risk of harm at Ashley Youth Detention Centre**

Ashley Youth Detention Centre did not adequately consider the risk to Max of him being placed in the Franklin Unit, despite concerns being raised about Max's safety. Max was exposed to an unacceptable risk of harm.

### **3.2.16 22 August 2019—A staff member reports the harmful sexual behaviours Henry experienced to Child Safety Services**

A week after expressing her view that Child Safety Services should be notified of the 7 August 2019 incident involving Henry, Ms Gardiner had received no response from the Centre Support Team or Mr Ryan, so she revisited the matter with Mr Ryan.<sup>1023</sup> On 21 August 2019, Mr Ryan responded, stating there were 'varying views on [the] level of seriousness of the matters' and while he was not 'convinced' a Child Safety Services notification was necessary, he was 'happy to take more argument on it'.<sup>1024</sup> Ms Gardiner responded the next day, stating she would advise Child Safety Services of the incident and leave it to them to determine whether it was to be a notification that required further follow-up.<sup>1025</sup>

On 22 August 2019, Ms Gardiner reported the incident involving Henry to Child Safety Services' Advice and Referral Line.<sup>1026</sup> Advice and Referral Line records indicate Ms Gardiner reported that Albert and Finn were masturbating in the TV room before the incident with Henry.<sup>1027</sup> Ms Gardiner also provided further information about an incident involving another young person on 8 August 2019 (where he was subjected to a resident 'exposing himself and masturbating') and lodged a care concern about Max in relation to his placement with Albert and Finn.<sup>1028</sup>

The records of Ms Gardiner's call with the Advice and Referral Line also suggest there was a discussion about the need to notify police.<sup>1029</sup> On 23 August 2019, Ms Gardiner emailed Mr Ryan, saying that Child Safety Services told her they would make a report to police.<sup>1030</sup>

Mr Ryan told us he had escalated the 7 August 2019 incident and Child Safety Services' report to Mr Brown, who advised him to leave the matter to the police.<sup>1031</sup> Mr Brown said he does not recall advising Mr Ryan to leave the matter to the police.<sup>1032</sup>

There appears to have been confusion, however, between Ashley Youth Detention Centre and Advice and Referral Line staff about who would notify police, with each entity believing the other would make the notification.<sup>1033</sup> By early October 2019, no police notification had been made.<sup>1034</sup> The Advice and Referral Line notified police of the incident on 3 October 2019 after an Ashley Youth Detention Centre staff member

informed them the Centre had not made a referral about the incident.<sup>1035</sup> The Advice and Referral Line file of the incident was closed on 11 November 2019.<sup>1036</sup>

Police records confirm that police were first notified of the incident on referral from Child Safety Services. However, they did not proceed with an investigation because ‘no formal complaint’ had been made.<sup>1037</sup> We note that the lack of a formal complaint should not be the sole reason for police inaction, particularly when there may be serious barriers for a victim-survivor making a formal complaint.

### **3.2.17 22 August 2019—The Ashley Youth Detention Centre psychologist recommends risk management of harmful sexual behaviours**

Also on 22 August 2019, the Centre’s psychologist emailed Ms Gardiner a spreadsheet she had prepared after reviewing footage of incidents in the Franklin Unit.<sup>1038</sup> The spreadsheet summarised incidents of sexualised and non-sexualised threatening and harmful behaviours displayed by Albert and Finn, including the 7 August 2019 incident involving Henry.<sup>1039</sup> The summary does not appear to address all matters or incidents identified in the various incident reports lodged on 9 and 10 August 2019.

In the email to Ms Gardiner, the psychologist noted disagreement about the ‘nature and the seriousness of the behaviours’ seen in the Franklin Unit.<sup>1040</sup> The psychologist reasoned that this disagreement could be explained by differences in individual and work experience, the extent of staff training and a:

... general tendency [among Ashley Youth Detention Centre staff] to minimise or dismiss young people’s sexually abusive behaviour as experimentation or play, or as a ‘phase’ that will pass with age ... which inadvertently perpetuates the cycle of abuse.<sup>1041</sup>

The psychologist’s view was that Finn and Albert had displayed ‘concerning and developmentally inappropriate sexual behaviours’.<sup>1042</sup>

The psychologist recommended the following responses:

- further investigation of the incidents
- urgent development of clear risk management strategies, such as increased supervision of the young people who displayed sexually abusive behaviours
- staff training
- more discussion about appropriate therapeutic interventions.<sup>1043</sup>

Ms Gardiner forwarded the psychologist’s advice to Mr Ryan on the same day, noting the Centre had ‘some work to do to upskill staff in this area. It is a significant risk otherwise’ and repeating a request for education/training from a sexual assault service.<sup>1044</sup> Mr Ryan responded to Ms Gardiner, stating that he believed the Department of Education had booked training for Centre staff through the Sexual Assault Support Service for the 2019

school year and encouraged Ms Gardiner to engage the Sexual Assault Support Service for resident programs.<sup>1045</sup> Mr Ryan directed Ms Gardiner to work with the Learning and Development Manager, Strategic Youth Services at the Department of Communities to arrange staff training.<sup>1046</sup>

Ms Gardiner told us she was particularly concerned that:

... staff in leadership positions were not aware of [harmful sexual behaviours] and this had created a situation of sexual abuse in the Centre, and would create more risk for young people in the future if this was not addressed.<sup>1047</sup>

Over an extended period, Ms Gardiner had contacted several senior staff at the Centre and in the Department to request group training on harmful sexual behaviours, but she said she received no response.<sup>1048</sup>

Mr Ryan provided information to our Commission of Inquiry that during the time he managed the Centre, a number of relevant training programs were provided for staff.<sup>1049</sup> He also made repeated attempts to arrange for the Sexual Assault Support Service to deliver training for Centre staff in relation to harmful sexual behaviours.<sup>1050</sup> He stated that in 2019 the program was implemented for detainees at Ashley School, with the support of the Principal.<sup>1051</sup> However, training for staff was not implemented because, according to Mr Ryan, successive directors did not support the training and Ms Honan noted the request but took no further steps to implement training.<sup>1052</sup>

Mr Brown informed us that sometime between October 2018 and October 2019, at his recommendation, the Department agreed to review staff training programs, including in relation to harmful sexual behaviours, at the Centre.<sup>1053</sup> It is not clear if this review was undertaken, or what the outcome of any such review was.

Ms Honan told us that training for recognising and responding to harmful sexual behaviours is now offered to staff.<sup>1054</sup> Such training will need to be supported by a cultural change of attitudes towards harmful sexual behaviours (refer to Chapter 12).

### **3.2.18 23 August 2019—The Centre Support Team again discusses the behaviours of Albert and Finn**

On 23 August 2019, a further Interim Centre Support Team meeting was held. The meeting minutes reflect that Albert and Finn had progressed to the green colour level. There was no mention of the 7 August 2019 incident involving Henry, progress in relation to conferencing with Albert and Finn, or any actions to address their behaviour.<sup>1055</sup>

Despite the recommendation of the Centre Support Team that Albert and Finn be dealt with by conferencing, it appears that conferencing never took place because of the following factors:

- The Conference Convenor decided to pause the process until a Child Safety Services report was made and responded to.<sup>1056</sup> The Conference Convenor also indicated that if police were notified, she would wait until the end of that process.<sup>1057</sup>
- Police were not notified until 3 October 2019.<sup>1058</sup>
- Henry was subsequently released from Ashley Youth Detention Centre in late October 2019.<sup>1059</sup>
- Child Safety Services did not close their investigation until 11 November 2019.<sup>1060</sup>

Moving Albert and Finn to a green colour level appears to contradict the Centre Support Team decision made on 12 August 2019 that Albert and Finn would not progress beyond orange until a conference had been completed.<sup>1061</sup> While we hold serious concerns about the Behaviour Management System and particularly its use as a tool for punishment, which we discuss in Chapter 12, it is important that if in use it should be applied equally and consistently. It is important that any behaviour management process should be experienced by children and young people in detention as fair, equitable and predictable to support strong relationships between detainees and to promote their sense of security.

We are concerned that Albert and Finn did not appear to receive conferencing or any other therapeutic support for the behaviours they had exhibited. It is also important that the Centre sends a clear message to children and young people displaying or experiencing harmful sexual behaviours that such behaviour is not acceptable.

### **3.2.19 9 September 2019—The Secretary is briefed about the 7 August 2019 incident involving Henry**

In his written statement to us, Mr Ryan confirmed he reviewed the CCTV footage of the 7 August 2019 incident involving Henry.<sup>1062</sup> He described the incident as ‘an attempt by two residents to remove the pants of a third resident’.<sup>1063</sup> In a further written statement, Mr Ryan recalled that the footage showed an ‘attempt’ to pull Henry’s pants down and that Henry’s ‘trousers [were] pulled part way down but his underpants remained on’.<sup>1064</sup> Mr Ryan states that he also showed the footage to Mr Brown, who ‘shared my view that it was appropriate to treat this as a sexualised incident, rather than a sexual assault’.<sup>1065</sup>

We asked Mr Brown about what information he received regarding this incident. He could not recall what information he received or when he received it and did not mention viewing the CCTV footage or his interpretation of it at the time.<sup>1066</sup> He subsequently recalled viewing the CCTV footage but, aside from recalling that the footage was ‘grainy’, he could not recall what it showed.<sup>1067</sup> Mr Brown disputes that he and Mr Ryan shared a view as to how the incident should be described and treated.<sup>1068</sup>

On 2 September 2019, approximately one month after the 7 August 2019 incident involving Henry, Mr Ryan prepared an issues briefing for Michael Pervan, the then Secretary of the Department of Communities, about the incident.<sup>1069</sup> The issues briefing was cleared through Mr Brown on 3 September 2019, then by Ms Honan, who at that time held the role of Acting Deputy Secretary, Children and Youth Services, on 6 September 2019.<sup>1070</sup> The issues briefing confirms that Mr Brown had viewed the CCTV footage of the incident.<sup>1071</sup>

The issues briefing was titled ‘Sexualised incident between residents at the Ashley Youth Detention Centre’.<sup>1072</sup> Its stated purpose was to brief the Secretary on the ‘sexualised incident’ on 7 August 2019 and the related referral to police about the alleged abuse.<sup>1073</sup>

The issues briefing referred to the incident as a ‘sexualised incident’ and a ‘potential sexual assault’.<sup>1074</sup> It described the CCTV footage as showing:

... the four residents in the [common] room ... [Finn] and [Albert] approach [Henry] and grab his legs, pulling him off his chair, and attempting to remove his track pants. [Henry] holds onto his pants and is able to keep them up. [Albert] reaches for a 600-millilitre water bottle and brings it towards [Henry’s] buttocks for two to three seconds. The incident then ends.<sup>1075</sup>

We note that Henry’s buttocks were exposed, which this description implies was not the case.

The issues briefing also stated:

- Henry had not made a complaint, but staff moved Henry from the Franklin Unit on 8 August 2019 as part of an ‘immediate operational response’ while an ‘inquiry’ continued.<sup>1076</sup> Jonathan was also moved from the unit on 9 August 2019 because it was ‘considered prudent to do so’.<sup>1077</sup>
- Albert and Finn were reported for a detention offence and referred to the psychologist.<sup>1078</sup> The briefing does not acknowledge that Finn declined to engage with the psychologist.
- Matters were and continued to be monitored via the Centre Support Team and Multi-Disciplinary Team processes.<sup>1079</sup>
- The Professional Services Team and the psychologist considered the incident. Ms Gardiner still ‘held concerns that the matter was an assault’ and referred the incident to the Advice and Referral Line.<sup>1080</sup>
- Representatives of the Advice and Referral Line agreed the incident was an alleged abuse and advised Centre staff to contact police.<sup>1081</sup>
- The incident had been referred to police.<sup>1082</sup> We note this is incorrect—a police referral was not made until 3 October 2019, almost a month after the Secretary approved the issues briefing.

- To that date, police had ‘not been in contact’ with the Centre about this matter, ‘but historically do so upon receipt of such referrals’.<sup>1083</sup>
- ‘[N]o further complaints or issues [had] been raised or identified since 8 August 2019’.<sup>1084</sup> We note that the issues briefing does not clarify that the psychologist and the Health and Community Services Union delegate had separately raised concerns about the incident with Mr Ryan.
- Police may charge Albert and/or Finn and the related detention offence reports had been filed pending the outcome of any charges.<sup>1085</sup>
- Various incidents had occurred between Henry, Albert and Finn over the period of 7–8 August 2019, which ‘could be described as wrestling and/or adolescent behaviour, or as unwanted attention’.<sup>1086</sup> These incidents were recorded and considered.<sup>1087</sup>

The issues briefing did not invite the Secretary to take any action or make any decision. The Department did not take any further action in response to the issues briefing.

Mr Ryan denied his description in the issues briefing was inaccurate but accepted the description could have been worded better.<sup>1088</sup> When asked about the issues briefing during our public hearings, Mr Ryan emphasised his lack of control over the final product that went before the Secretary. Mr Ryan said it was common that the contents of briefings were changed as they were considered and edited by his superiors, through whom briefings were approved.<sup>1089</sup> He commented that what he ‘initially authored isn’t exactly what the recipient gets’.<sup>1090</sup>

Mr Ryan provided a draft of the relevant issues briefing, dated 30 August 2019.<sup>1091</sup> The contents of this draft are similar to the final product. Some important differences are that Mr Ryan’s draft:

- stated that the allegation was referred to Child Safety Services, which had on-referred the matter to police to consider<sup>1092</sup>
- attached the referral advice provided to Child Safety Services, containing the opinion of its author, Ms Gardiner<sup>1093</sup>
- stated Mr Ryan had considered the incident and CCTV footage and ‘suggests the incident is sexualised behaviour, but not an Assault’.<sup>1094</sup>

The description of the incident contained in the draft and final briefing are the same. The two briefs indicate the matter is a ‘sexual incident’, but the original draft makes it clearer that Mr Ryan did not believe the matter to be ‘an Assault’.

The Director, Strategic Youth Services, who has since retired, could not recall many details of the 7 August 2019 incident or the issues briefing. He said:



I do not recall what information I received and when I received it in relation to this incident. I would be quite sure I would have initially received a phone call outlining basic details and possibly a follow up email. I would generally then receive the incident report and a follow up Issues Brief. I would advise the Deputy Secretary (generally verbally) then follow up with written details through email or an Issues Brief ...

I do not recall whether I sought additional information or received additional information or not. In general practice, before clearing an Issues Briefing I would clarify any matters I was not sure about or felt required additional information. I am not sure if I did that on this occasion or not.<sup>1095</sup>

Ms Honan, as Acting Deputy Secretary, stated that she did not conduct any further investigation about the matter before approving the issues briefing.<sup>1096</sup> Ms Honan noted that Mr Ryan and Mr Brown (both of whom had been involved in preparing the issues briefing) had seen the CCTV footage of the incident.<sup>1097</sup> She also acknowledged that the matter had been referred to police and Child Safety Services, and that the young people had been referred to the psychologist about their behaviours.<sup>1098</sup> She told us that, because of these actions, she had ‘no reason to doubt the content’ of the issues briefing.<sup>1099</sup>

In her statement to us, Ms Honan reflected that she considered the issues briefing of 9 September 2019 appeared to minimise the behaviour of Albert and Finn and did not, as noted in the Serious Events Review Team report, depict an accurate description of the 7 August 2019 incident, and was misleading.<sup>1100</sup>

Department Deputy Secretary Mandy Clarke also agreed the issues briefing minimised the incident and showed a lack of understanding of harmful sexual behaviours.<sup>1101</sup>

Secretary Pervan disagreed the issues briefing minimised the incident overall but acknowledged and accepted the later findings of the Serious Events Review Team that the briefing provided an inaccurate description of the incident.<sup>1102</sup> Secretary Pervan considered that, in this respect, the issues briefing ‘painted the incident in a less severe light’.<sup>1103</sup> Secretary Pervan gave evidence that if the issues briefing had been more accurate, he would have initiated the Serious Events Review Team’s review sooner.<sup>1104</sup>

It was not until Alysha raised concerns that Ms Honan may not have been fully informed about the incident that a Serious Events Review Team review began in December 2019.<sup>1105</sup> We discuss this review further in this case study.

## **Finding—The issues briefing to the Secretary about the 7 August 2019 incident regarding Henry minimised the incident and was incomplete, which contributed to a delay in reviewing the incident**

The following information was available to Ashley Youth Detention Centre and the Department:

- Albert and Finn forcibly removed Henry from his chair and held him down.
- Albert and Finn’s conduct was of a sexual nature.
- Henry’s pants were forcibly removed to the extent that his buttocks were exposed.
- Henry was isolating himself in his room, seemingly as a result of the incident and comments from Albert.
- Albert and Finn had discussed a sexual abuse of Henry with other detainees and staff.

This information should have made it clear that an incident of serious harmful sexual behaviour had occurred. It should have been reported as such to the Secretary.

As a result of an insufficient briefing, the Department was not appropriately informed of the severity of the incident and the potential risk to other young people at Ashley Youth Detention Centre. In turn, the incomplete issues briefing likely contributed to the Department delaying action to investigate or otherwise manage the incident.

### **3.2.20 18 September 2019—The Ashley Youth Detention Centre psychologist alerts the Centre Manager of Henry’s exposure to a risk of harm**

We were concerned by evidence that in the weeks following the incident, operational decisions meant Henry was again exposed to a risk of harm from Finn. On 18 September 2019, the psychologist raised concerns that Henry had been moved into a program group with Finn, despite the lack of any formal interventions and without consultation with the Multi-Disciplinary Team.<sup>1106</sup> On 20 September 2019, the psychologist requested (via email) that Mr Ryan reverse this decision immediately.<sup>1107</sup> In this email, she stated:

I believe that some of the reasons provided for the decision (this is secondary information as I was not at the morning meeting in person) were that the investigation is likely to be closed without any further actions due to the insignificant nature of the incident, and that [Henry] and [Finn] have since been in each other’s company (for example, in the dining hall) without any issues observed by the youth workers. As I am sure you can appreciate there are a number of issues with such rationale.<sup>1108</sup>

We understand the psychologist's reference to an 'investigation' at this time refers to the internal consideration of the incident within the Centre and the Department, rather than an official investigation such as that subsequently undertaken by the Serious Events Review Team, as we have seen no evidence to suggest that a formal investigation started before December 2019 (discussed in a further section). It is unclear whether Henry was removed from the program with Finn.

### **Finding—In the weeks following the 7 August 2019 incident, Henry continued to be exposed to risk of harm at Ashley Youth Detention Centre despite widespread knowledge about these risks**

Based on the evidence and findings covered in the Serious Events Review Team report into the incident, as well as our own viewing of the CCTV footage of the incident, it appears that Henry experienced serious harmful sexual behaviour on 7 August 2019.<sup>1109</sup>

Ashley Youth Detention Centre did not demonstrate an appreciation of the seriousness of the incident involving Henry on 7 August 2019. Some staff appeared to understand the seriousness of this incident. However, we were concerned that other staff described the matter as a 'sexualised incident'.<sup>1110</sup> This was despite multiple concerns being raised about this, including on:

- 10 August 2019, when another incident report was prepared about Albert and Finn discussing the incident and making further sexualised comments
- 12 August 2019, when the Centre Support Team discussed the sexualised behaviours of Albert and Finn
- 13 August 2019, when Ms Gardiner emailed Mr Ryan and other members of the Centre Support Team emphasising that Albert and Finn's behaviours were inappropriate
- 19 August 2019, when the Centre Support Team again discussed Albert and Finn's behaviour and the psychologist noted a pattern of behaviour that needed to be addressed
- 22 August 2019, when Ms Gardiner reported the incident involving Albert and Finn to Child Safety Services.

This minimisation of the incident resulted in:

- insufficient supports provided to Henry after the incident
- not taking immediate action to protect Henry's safety

- failure to develop a program to address Albert and Finn’s behaviour
- delayed reporting to police and Child Safety Services.

We are concerned the advice of staff who had knowledge and understanding of harmful sexual behaviours and the management of such behaviours, appears not to have been given as much sway as the concerns and views of operational staff.

Consequently, young people continued to be placed with Albert and Finn for several months and were at continued risk of sexual harm. We are particularly concerned by evidence that Henry was placed in programs with Finn in the weeks following the 7 August 2019 incident.

### 3.2.21 September 2019—Ray is admitted to Ashley Youth Detention Centre

In September 2019, Ray was admitted to Ashley Youth Detention Centre. Soon after Ray’s admission, the Multi-Disciplinary Team recommended the Centre Support Team place Ray on a Very Close Supervision order until more was known about his history and current mental health.<sup>1111</sup> It does not appear that Ray was placed on a Very Close Supervision order until towards the end of his third month at the Centre (as discussed further in this section).

Approximately one week after his admission, Ray abused another young person and was isolated for 50 minutes.<sup>1112</sup> Ray continued to be involved in a range of physical incidents in the weeks following his admission. Ray was again isolated after at least one other incident.<sup>1113</sup> Ray’s mental health difficulties were not reflected in incident forms completed following these incidents.<sup>1114</sup> Conferences were held with Ray regarding some of these incidents.<sup>1115</sup> Following these conferences, Ray was directed to continue to see the psychologist.<sup>1116</sup> In at least two conferences, it was noted that Ray was ‘very insightful about his behaviour’.<sup>1117</sup>

A version of Ray’s care plan was updated approximately one month after his admission. The care plan noted a recommendation by the Multi-Disciplinary Team that ‘a “Key Worker” be identified at each shift to support and monitor [Ray] and to report any behaviour concerns’.<sup>1118</sup> The intention was not ‘that a worker be specifically dedicated to [Ray], but rather has a consistent oversight’, to help Ray build relationships and create some stability in his environment.<sup>1119</sup> Later emails sent between Professional Services and Operations Team members suggest this recommendation was, at least initially, received positively by at least one Operations Team member.<sup>1120</sup>

We note there were discrepancies in the various incident reports concerning Ray, including forms apparently filled out without reference to the actual events, and some forms that were not filled out appropriately or were incomplete.

### **3.2.22 8 October 2019—The Ashley Youth Detention Centre psychologist reports harmful sexual behaviours to the Commissioner for Children and Young People**

On 8 October 2019, the Ashley Youth Detention Centre’s psychologist contacted Leanne McLean, the Commissioner for Children and Young People, to advise her of the 7 August 2019 incident and another incident of harmful sexual behaviour in October 2019 by Albert and Finn.<sup>1121</sup>

### **3.2.23 13–14 November 2019—The Ashley Youth Detention Centre psychologist raises more concerns with the Centre Manager about Albert and Finn**

On 13 November 2019, the psychologist emailed Mr Ryan to advise of a young person in detention disclosing to her that staff had threatened to transfer him to the Franklin Unit, that he felt unsafe and stated that detainees get ‘stood-over, abused and raped’ in the Franklin Unit.<sup>1122</sup> This conduct referred to Albert and Finn’s behaviours.<sup>1123</sup> We are unaware of which young person expressed this concern but based on the timing it appears unlikely to be (but could be) Max, Henry or Ray.

Mr Ryan told us he ‘was taken aback by her assertions because they didn’t square with [his] understanding of how residents were being treated or the history of complaints which had been received prior’.<sup>1124</sup> In response to this email, Mr Ryan told us he:

- spoke with Digby (a pseudonym), the co-manager of Professional Services (we note Ms Gardiner’s employment at the Centre ceased in mid-October 2019), and senior social workers
- convened a ‘special meeting’ of managers on 20 November 2019 to discuss Albert and Finn’s behaviour
- held regular weekly meetings for the remainder of 2019 and into February 2020 to monitor Albert and Finn’s behaviour and provide a ‘higher level of intervention’.<sup>1125</sup>

It is unclear to us what action was taken in response to the allegations that staff had threatened young people with a transfer to the Franklin Unit, separate from the response to the behaviours Albert and Finn exhibited.

In a meeting on 14 November 2019, the Multi-Disciplinary Team recommended that ‘no other residents will be placed in Franklin until a clear plan is in place’.<sup>1126</sup>

### 3.2.24 15 November 2019—The Ashley Youth Detention Centre psychologist documents her concerns about Albert and Finn in a letter to the Centre Manager

With the support of her supervisors in the Department to raise concerns, the Centre’s psychologist sent a letter to Mr Ryan on 15 November 2019.<sup>1127</sup> This letter was also copied to the Director of Nursing, Statewide Forensic Mental Health Services, Department of Health and Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, who were senior health staff in the psychologist’s reporting line.<sup>1128</sup>

The letter summarised ‘previously voiced concerns’ and identified the following concerns associated with the management of Albert and Finn:<sup>1129</sup>

- There was a ‘[h]igh risk of harm and traumatisation to youth placed in the Franklin Unit, perpetrated by [Albert] and [Finn], on particularly younger residents, those smaller in physical stature and those with disabilities’.<sup>1130</sup>
- There was a ‘chronic sense of being unsafe and risk of vicarious trauma to [Centre] residents in general who are aware of the incidents of intimidation and sexualised behaviour in the Franklin Unit and who are also aware of the lack of sanctions associated with these incidents’.<sup>1131</sup>
- Current practice risked reinforcing to Albert, Finn and other young people that this kind of behaviour was an acceptable way ‘to get [one’s] needs met and is a successful strategy to keep one safe from the abuse of others’.<sup>1132</sup>
- There was ‘insufficient and [in]accurate documentation’ at the Centre that could lead to courts or community agencies receiving misleading information.<sup>1133</sup>
- There was a range of long-term risks, including ‘significant risk of physical and psychological harm, poor staff morale, and the corruption of the system entrusted with the care of some of the most vulnerable youth in the state’.<sup>1134</sup>

To mitigate those risks, the psychologist stated that ‘clear interventions and consistent enforceable sanctions’ were required as ‘a matter of priority’.<sup>1135</sup> The psychologist identified a need to formally assess whether Ashley Youth Detention Centre was sufficiently resourced to address Albert and Finn’s specific needs and to prepare a management plan.<sup>1136</sup>

The psychologist also contended there was ‘evidence of lack of consultation and adherence to the decisions and recommendations made by the Centre Support Team and Multi-Disciplinary Team’.<sup>1137</sup> She expressed her view that it was essential all professional disciplines across the Centre support implementing the management plan.<sup>1138</sup>

The psychologist recommended that, as an interim measure, other young people should not be placed in the Franklin Unit until safe measures had been implemented ‘to ensure their safety with regards to the abolishment of the clear pattern of “ganging-up” and victimisation’.<sup>1139</sup>

Mr Ryan gave evidence that the Director of Nursing and the Nurse Unit Manager had read the psychologist’s letter to him, dated 15 November 2019, and did not accept its assertions.<sup>1140</sup>

Emails sent in the week following 15 November 2019 indicate that the Director of Nursing and Mr Ryan spoke about the psychologist’s letter. In his statement, Mr Ryan noted an email he had sent to Piers (a pseudonym), who held a leadership role at Ashley Youth Detention Centre at the time, which reads in part that ‘[the Director of Nursing] states that he has been over [the psychologist’s] clinical notes, leading [the Director of Nursing] to state “I believe this to be an operational issue”’.<sup>1141</sup>

In evidence to us, the Nurse Unit Manager disagreed with Mr Ryan’s recollection that she reviewed the psychologist’s letter at the time, stating that she did not see the psychologist’s letter before 4 February 2020.<sup>1142</sup> She did, however, recall a conversation with the Director of Nursing about ‘an alleged sexualised behaviour incident which occurred in early August’, but could not recall the exact date.<sup>1143</sup> The Nurse Unit Manager told us that during this conversation, she expressed her opinion that she did not interpret the behaviours of Albert and Finn to be ‘a serious sexual assault’.<sup>1144</sup> The Nurse Unit Manager told us she formed this opinion after she reviewed the CCTV footage and spoke with the young people in detention (including Henry), who she reported ‘all said that they were “just mucking around”, and that there was no intent to cause anybody harm’.<sup>1145</sup> The Nurse Unit Manager said that, in hindsight, she believed ‘this was probably “bravado” and an attempt to deflect possible retaliation on [Henry’s] part’.<sup>1146</sup> The Nurse Unit Manager stated that she would not have done anything differently, but had she been privy to all the information at the time, she could have supported the psychologist in monitoring Henry’s wellbeing.<sup>1147</sup>

The Director of Nursing also disagreed with Mr Ryan’s recollection, stating that he in fact agreed with the psychologist’s concerns.<sup>1148</sup>

Mr Brown could not recall the 7 August 2019 incident and retired from the Department in October 2019.<sup>1149</sup>

There is evidence to suggest that in response to the letter, Mr Ryan told the psychologist that a task team would be created to develop an intervention plan for Albert and Finn.<sup>1150</sup>

In an email to Piers on 22 November 2019, Mr Ryan noted that he had spoken with the psychologist on 21 November 2019 to discuss ‘action items’ and that ‘she appeared pleased’.<sup>1151</sup>



Mr Nicholson also told us the concerns the psychologist raised in her letter of 15 November 2019 were legitimate clinical concerns.<sup>1152</sup> He stated that these concerns should have been taken seriously but were not.<sup>1153</sup>

We return to the discussion between the Department, the psychologist and the Centre below (refer to January 2020).

### **3.2.25 Early December 2019—Behaviour management programs are initiated for Albert and Finn**

In late November 2019, the Multi-Disciplinary Team tasked Alysha and the psychologist with creating and implementing an intensive behaviour management program for Albert and Finn.<sup>1154</sup> In early December 2019, the psychologist and Alysha conducted a review into Albert and Finn’s behaviour over the preceding 12 months.<sup>1155</sup>

Alysha told us that as part of their review she and the psychologist reviewed the CCTV footage of the incident and other incidents from 7 and 8 August 2019.<sup>1156</sup> Their review indicated there were five other incidents of intimidating behaviours in that period, including sexualised behaviour.<sup>1157</sup> Albert and Finn were involved in all these incidents.<sup>1158</sup>

Alysha recalled that she and the psychologist also identified a series of incident reports prepared by youth workers that noted conversations in which Finn discussed serious sexual abuse perpetrated by Finn and Albert against younger and smaller boys in the Franklin Unit.<sup>1159</sup> Alysha told us that those incident reports were marked as ‘recorded incidents’ and left blank in a number of sections, including regarding notifications, CCTV footage, the involvement of other agencies and further action to be taken.<sup>1160</sup> Among these incident reports were documents lodged on 9 and 10 August 2019 in which staff reported discussions between detainees about the 7 August 2019 incident, as well as other harmful sexual behaviours by Albert and Finn.<sup>1161</sup> We understand those reports cover the same incidents as those described above.

Alysha told us that she and the psychologist immediately notified Mr Ryan and Piers about the numerous incidents involving Albert and Finn.<sup>1162</sup> We understand this occurred on or around 6 December 2019.<sup>1163</sup>

Alysha’s view was that the ‘most urgent’ task was to ensure the safety of other children and young people in detention and provide intensive therapeutic interventions for Albert and Finn.<sup>1164</sup> Alysha told us she was concerned the issues documented in the incident reports had not been reported to police and that children were still being placed in the same unit as Albert and Finn.<sup>1165</sup>

Alysha’s evidence was that Mr Ryan and Piers ended the review she and the psychologist were conducting.<sup>1166</sup>

We asked Digby, the former co-manager of Professional Services, about the response to concerns raised about Albert and Finn. He responded that he was aware the psychologist, Alysha and another member of staff ‘undertook to develop an appropriate tailored management plan to meet the needs of both boys’ but that to his knowledge, the plan was never finalised.<sup>1167</sup>

Piers told us that Alysha and the psychologist were restricted from accessing files on advice from Mr Ryan.<sup>1168</sup> Piers recalled the reason for that advice to be:

Prior to this both staff were freely accessing said files without authority and in some cases, it appeared to have no immediate bearing on their workloads especially in relation to the role that Alysha was employed to do.

In the case of [the psychologist], she was employed by Forensic [Mental] Health and as such being a separate department, there was a protocol to accessing clients’ files.

However, to compensate for this, a daily information meeting was started between [the psychologist], Operations Manager and Operations Coordinator to brief on incidents or concerns from previous shifts. She did have unrestricted access to incident reports and [Centre Support Team meeting] minutes.

Both staff were able to move forward with access to any files that they considered important to their work, however they needed to seek authority from their manager to do so.<sup>1169</sup>

In relation to developing a behaviour management plan for Albert and Finn, Mr Ryan told us that although he was aware Alysha and the psychologist were tasked with undertaking a review of Albert and Finn’s behaviours, he was not aware they were accessing ‘any and every file they wished, against the parameters’ set by the managers of the Professional Services Team.<sup>1170</sup> He told us:

I spoke with [the co-managers of the Professional Services Team] about the unfettered access to files. Both assured me that this was not agreed to with anyone, but that their office was to work with [the psychologist] in preparation of the Plan. Both [managers] felt that ... [Alysha] granted access to any file or correspondence sought and that this was against their set parameters. Both indicated that they would speak with all parties involved.<sup>1171</sup>

Mr Ryan denied that he interfered with the development of a behaviour management plan for Albert and Finn.<sup>1172</sup> We understood him to mean that he did not interfere unreasonably or without justification, noting that he did engage with the managers of the Professional Services Team to raise concerns about access to files outside of ‘set parameters’.<sup>1173</sup>

### 3.2.26 Early December 2019—Staff continue to raise concerns about Albert and Finn

Alysha told us that after speaking with Mr Ryan and Piers on 6 December 2019, she notified the Advice and Referral Line of all the incidents involving Albert and Finn.<sup>1174</sup> The psychologist also made a mandatory report to Child Safety Services on 6 December 2019 about the 7 August 2019 incident involving Henry.<sup>1175</sup> On the same day, the psychologist emailed Mr Ryan stating that, following the discovery of the incident reports—which contained allegations of attempted rape and verbal threats of rape, incidents of sexual favours performed for compensation, and that sexual frustration was being taken out on younger residents in the Franklin Unit—she had made mandatory reports to Child Safety Services and the Commissioner for Children and Young People.<sup>1176</sup>

By December 2019, Ms Honan had assumed the role of Director, Strategic Youth Services (now Director, Youth and Family Violence Services).<sup>1177</sup> On 6 December 2019, Mr Ryan forwarded to Ms Honan the psychologist’s email about her report to Child Safety Services.<sup>1178</sup> Mr Ryan told Ms Honan that he did not agree with the psychologist’s assertions.<sup>1179</sup> He also told Ms Honan that he had urged the psychologist to be cautious until he had checked the Centre Support Team records, but that the psychologist ‘declined to wait and said she had no option but to report those findings to [Child Safety Services]’.<sup>1180</sup> He concluded the email by writing that the psychologist had ‘strong, emotive opinion in respect to this matter’ and that the Director of Nursing and the Nurse Unit Manager had recently disagreed with the psychologist.<sup>1181</sup>

Alysha told us that, on both 5 and 6 December 2019, she called Ms Honan’s Executive Officer to tell her about the incident reports and Mr Ryan and Piers’ response.<sup>1182</sup> Alysha recalled that she told the Executive Officer she wanted to contact police about the matter immediately, but the Executive Officer told her to wait and to speak with Ms Honan the following week.<sup>1183</sup> On 6 December 2019, Alysha also emailed the Executive Officer, stating:

I have reached a point where if I lose my job for reporting practices in place, it will be worth it to shine a light on the issues and practices that are currently in place at Ashley. Someone would need to further examine all residents incident reports to get a full picture of the lack of adequate documentation, follow up and interventions put in place to support staff, victims and perpetrators of said incidents.

Please note that it is my understanding there is currently [paper-based] handover and incident reports at Ashley. There are only originals and no copies electronically or paper based.<sup>1184</sup>

Alysha sent photographs of the incident reports to the Executive Officer.<sup>1185</sup>

In her response of the same date, the Executive Officer stated that she appreciated Alysha giving Ms Honan ‘an opportunity to discreetly investigate this first before contacting external agencies’ and assured Alysha that Alysha had met her duty of care.<sup>1186</sup>

### **3.2.27 6 December 2019—The Ashley Youth Detention Centre psychologist again reports harmful sexual behaviours to the Commissioner for Children and Young People**

On 6 December 2019, the Centre’s psychologist again contacted Commissioner McLean after discovering the incident reports related to Henry.<sup>1187</sup> The psychologist provided the Commissioner with the spreadsheet of incidents she had prepared in August 2019.<sup>1188</sup> The psychologist was troubled that nothing had happened to manage Albert and Finn’s behaviours, despite her letter of 15 November 2019 to Mr Ryan outlining her concerns.<sup>1189</sup>

On the same day, Commissioner McLean contacted Ms Honan to discuss the psychologist’s disclosure.<sup>1190</sup> Ms Honan confirmed she was aware of concerns but did not have all the information.<sup>1191</sup> Ms Honan also confirmed that Mr Ryan had assured the immediate safety of all detainees over the weekend and that she would go to the Centre on the next business day to access information with a view to initiating a Serious Events Review Team review.<sup>1192</sup>

Commissioner McLean expressed support for Ms Honan’s approach during that conversation.<sup>1193</sup> Commissioner McLean commented that it seemed to her that the motivation for examining unwanted sexual behaviours among children and young people in detention ‘was low’ and ‘perhaps influenced by a custodial environment’.<sup>1194</sup> We understand this comment to mean Commissioner McLean was concerned that little attention was paid to harmful sexual behaviours at the Centre and that this attitude may have been influenced by a custodial rather than therapeutic attitude in the Centre.

### **3.2.28 9–10 December 2019—The Director, Strategic Youth Services initiates a review into the 7 August 2019 incident involving Henry**

Alysha told us she met with Ms Honan on 9 December 2019.<sup>1195</sup> Alysha recalled that Ms Honan said the Department would conduct an internal investigation and report the matter to the police if necessary.<sup>1196</sup>

On the same day, Commissioner McLean followed up with Ms Honan, who confirmed there was a need for a Serious Events Review Team review.<sup>1197</sup> Commissioner McLean supported initiating a review and advised Ms Honan she would write to the Department about the matter with the potential to refer it to the Custodial Inspector.<sup>1198</sup>

On 10 December 2019, Commissioner McLean wrote to Secretary Pervan to advise him of the psychologist’s concerns, enclosing the psychologist’s supporting material.<sup>1199</sup> Commissioner McLean further advised of her contact with Ms Honan and of her support for an immediate review.<sup>1200</sup> Commissioner McLean requested that she be kept up to date with the Serious Events Review Team process and advised that she may refer the matter to the Custodial Inspector.<sup>1201</sup>

We have received no evidence that the Custodial Inspector was notified of this incident or any other concerns the psychologist raised. During our public hearings, the Custodial Inspector, Richard Connock, told us he was not sure whether he had been informed at the time that the review was being conducted, but he agreed it was the kind of thing that would have been important for him to have been aware of.<sup>1202</sup>

We note that on 13 December 2019, there was an incident where three young people detained at Ashley Youth Detention Centre accessed a roof, there was a stand-off, and the three young people were subsequently ‘unit bound’, with allegations of staff falsifying isolation records (we discuss this incident and the Centre’s response in Case study 3).<sup>1203</sup>

### **3.2.29 Mid-December 2019—The Serious Events Review Team investigates the 7 August 2019 incident**

The Serious Events Review Team’s investigation into the 7 August 2019 incident involving Henry began in December 2019.<sup>1204</sup>

The terms of reference for the review were as follows:

#### **Background and Services History**

Review the process applied in recording, investigating, assessing and referral to required services of the alleged incident of sexual assault upon [Henry] in [Ashley Youth Detention Centre] in August 2019.

Determine and comment on the post incident management of this incident both for the alleged perpetrators, victim and other residents’ safety and wellbeing.

#### **Assessment**

Consider and analyse the presence/absence and quality of recorded information and assessments which guided the decisions made with regard to the placement, safety, referral to police/[Tasmanian Health Services], case planning and post incident management of [Henry] and others allegedly involved in this matter.

#### **Planning, Services and Communication**

Describe and analyse the quality of communication between [Ashley Youth Detention Centre] and other key internal and external stakeholders/service providers in this case.

Make comment on case processes, planning, and service provision and how these have served (or otherwise) to protect and enhance [Henry]’s safety and well-being at this time and over time.

#### **Compliance with Legislation and Policy**

Determine whether [Ashley Youth Detention Centre] has fulfilled its responsibilities as articulated in the Youth Justice Act 1997, Standard Operating Procedures and agency policy.

## Findings and Draft Recommendations

Articulate findings from this review and provide draft recommendations regarding any actions that should be taken to address issues identified in the review, as they relate to the above Terms of Reference.<sup>1205</sup>

Veronica Burton, a former Serious Events Review Team member, conducted the review and wrote the final report. We heard evidence about the difficulties that Ms Burton and others experienced when seeking to access records relevant to the review.

As part of the review, Ms Burton read a wide range of documentation, including electronic and paper files, email communication, meeting minutes and daily diaries, and watched CCTV footage.<sup>1206</sup> She also considered relevant legislation, policies and procedures.<sup>1207</sup> Interviews were conducted with past and current Centre staff, including management.<sup>1208</sup> We note that Mr Ryan said he was unwell and on extended leave during the period Ms Burton carried out the review and was largely unable to participate or contribute to the review process.<sup>1209</sup>

Both Alysha and Ms Burton told us about an occasion during Ms Burton's review where they said Piers prevented Ms Burton from accessing files stored in a filing cabinet and told her that he could not find other files she requested because they had been archived.<sup>1210</sup> Ms Burton told us that some of these records were provided by Stuart Watson when he replaced Mr Ryan as Centre Manager.<sup>1211</sup> Ms Burton recalled that during her review, she was prevented from speaking directly with Henry and therefore, never heard his version of the incident.<sup>1212</sup>

Piers could not recall the Serious Events Review Team attending the Centre to discuss the 7 August 2019 incident.<sup>1213</sup> He said that 'at no time would I have restricted them from accessing any files or reports and would have made available to them what was available to me'.<sup>1214</sup>

Ms Burton also told us that Piers provided her with incident reports about the 7 August 2019 incident.<sup>1215</sup> She believed these reports were not originals and had been rewritten.<sup>1216</sup> Ms Burton told us she received a second set of incident reports from Alysha.<sup>1217</sup> Ms Burton recalled that second set included different details about the incident, including the length of time the detainees were left unsupervised, who the matter was reported to and the severity of the incident.<sup>1218</sup> Ms Burton also told us the second set 'minimis[ed] how the ... bottle was used'.<sup>1219</sup> Ms Burton told us that her usual practice was to scan any hard-copy paper files and save them to the secure file system for the Serious Events Review Team and to then file the hard copies.<sup>1220</sup> She stated she does not have 'a clear memory of exactly doing that with those documents, but that was the process that I followed, so I can say with ... almost 100 per cent confidence that that's what occurred'.<sup>1221</sup> Ms Burton stated that she no longer had access to the Serious Events Review Team files after leaving the Department.<sup>1222</sup> We have only received one version of the relevant incident report from the Department, which Ms Burton believed to be the version she received from Piers.<sup>1223</sup>



Commenting generally on her engagement with Ashley Youth Detention Centre staff when conducting reviews into incidents at the Centre, Ms Burton told us she depended on the cooperation of Centre management to gain access to records and interviewees.<sup>1224</sup> Her experience was that it was sometimes difficult to access all the information she needed, including interviewing children, without staff assistance, saying ‘I couldn’t go anywhere in the centre unless somebody took me because every door is locked and I needed somebody to escort me wherever I needed to go’.<sup>1225</sup>

Ms Burton also observed that her access to children and young people in detention was limited because they were usually housed in secure units and so she would ‘often only get the staff version of events’.<sup>1226</sup> She said she was often not provided personal information or history about the young people involved.<sup>1227</sup> She expressed concerns to us about an approach at the Centre of a ‘clean slate’ philosophy that did not view children’s history of significant trauma as relevant, noting ‘[it] is no way to run a therapeutic service’.<sup>1228</sup>

Ms Burton noted that while the Centre had an electronic filing system, it was not in use and ‘pretty much everything was paper file’.<sup>1229</sup> Ms Burton told us that she depended on the Centre’s management to make paper files available to her and noted that this was different from other agencies, such as Child Safety Services, where Ms Burton would have automatic access to all electronic records.<sup>1230</sup> Ms Burton recalled that in her dealings with Ashley Youth Detention Centre, she often encountered issues of missing documents, a lack of records and, if records were provided, concerns about their accuracy.<sup>1231</sup> For example, Ms Burton recalled that, ‘because ... file-keeping was so poor’, she would often depend on management to identify which staff were rostered on during an incident under review.<sup>1232</sup>

### **3.2.30 December 2019—Ray is moved to the Franklin Unit**

Towards the end of his third month at the Centre, Ray was transferred to the Franklin Unit because the unit he was in had to be evacuated.<sup>1233</sup> At this time, Albert and Finn were still housed in the Franklin Unit.<sup>1234</sup> Minutes of the Centre Support Team meeting held two days after Ray’s transfer to the Franklin Unit showed the team did not raise the possibility of transferring Ray out of the Franklin Unit after the incident that caused the transfer.<sup>1235</sup>

We note that at this point, there had been a Multi-Disciplinary Team recommendation that no young people be placed with Albert and Finn until both had received appropriate interventions. That recommendation was made about one month before Ray was placed in the Franklin Unit (on 14 November 2019). The Centre’s psychologist reiterated this recommendation following the placement of Henry in the Franklin Unit in the week before Ray’s transfer to the Franklin Unit. We also note, as outlined, that when Ray was admitted to the Centre, the psychologist had made a general recommendation about the need to ‘carefully consider’ Ray’s unit placement considering his mental health difficulties.<sup>1236</sup>



### 3.2.31 December 2019—The Multi-Disciplinary Team raises concerns about Ray’s transfer to the Franklin Unit

In the days following Ray’s transfer to the Franklin Unit, minutes of a Centre Support Team meeting recorded that Ray had ‘settled well into Franklin’.<sup>1237</sup>

Minutes of a Multi-Disciplinary Team meeting held two days later included the following comments, under the heading ‘What are we worried about?’:

- ‘Recent move to Franklin could be a concern for [Ray]’.
- ‘[Ray] is highly suggestible to external influences’.
- ‘There are concerns about the current mix of residents in Franklin’.<sup>1238</sup>

The following comments were made about the recommended next steps for Ray:

- ‘Ideally to be moved from Franklin due to [Ray] being easily coerced and his ongoing mental health symptom’.
- ‘Reside with peers who are not going to influence [Ray] in an adverse manner’.
- ‘Youth workers reporting dysregulation. It is recommended a unit move’.<sup>1239</sup>

Around this time, Ray was made subject to a Very Close Supervision order.<sup>1240</sup>

A subsequent issues briefing (discussed below) indicates that this decision was made ‘during Centre Support Team and/or [Interim Centre Support Team] meetings’, which appears to be backed up by Centre Support Team meeting minutes of this period.<sup>1241</sup> Centre Support Team meeting minutes around this time indicate some discussion about Ray’s placement in the Franklin Unit, with a set of minutes noting:

Concerns regarding [Ray] being housed in Franklin were tabled, but staff felt that by putting [Ray] on [Very Close Supervision] this would eliminate the concerns raised around him possibly being influenced by others in the unit, particularly given his unsettled mental health.<sup>1242</sup>

We asked Mr Ryan about the decision to place Ray in the Franklin Unit. He responded it was a ‘difficult’ time at the Centre, that there were a ‘number of very challenging residents’ and that Ray’s behaviours were ‘extreme’.<sup>1243</sup> He said the options following the Multi-Disciplinary Team’s recommendation that Ray be moved from the Franklin Unit were either to move Ray out of the Franklin Unit or to keep him in the Franklin Unit under Very Close Supervision.<sup>1244</sup>

Mr Ryan said that to move Ray from the Franklin Unit to a less secure unit would have had ‘ramifications for [Ray] and for other residents and staff’.<sup>1245</sup> Mr Ryan described Ray’s continued placement in the Franklin Unit under Very Close Supervision as ‘the “least worst” option’.<sup>1246</sup> Mr Ryan also said a separate incident that occurred two weeks after Ray’s transfer to the Franklin Unit meant it was ‘very difficult to safely move [Ray] from Franklin to a less secure unit’.<sup>1247</sup>

The Very Close Supervision order required a supervising youth worker to always be within five metres of Ray when he was outside a locked building.<sup>1248</sup> We are unclear as to why, in this instance, the Very Close Supervision order seemingly applied only when Ray was outside, given he was likely at the same or increased risk of harm by other young people when inside a unit. However, it appears from the relevant procedure that this was standard practice.<sup>1249</sup> The practice was perhaps directed at managing an escape risk rather than protecting young people from harm.

Minutes of a Centre Support Team meeting held after the Very Close Supervision order was made recorded that he was ‘travelling well in Franklin’ but that he did ‘keep to himself’.<sup>1250</sup>

### **3.2.32 2 January 2020—An incident occurs involving Ray, Albert and Finn**

Approximately three weeks after Ray was transferred to the Franklin Unit, he was involved in a verbal altercation with Albert, after which Ray initiated a physical altercation with Albert.<sup>1251</sup> Finn also took part in this altercation and Ray received multiple punches to the head from Albert and Finn.<sup>1252</sup> This incident occurred indoors.<sup>1253</sup>

Documents prepared in the days following the incident show that Alysha and the psychologist believed Ray was provoked to violence when Albert and Finn made light of Ray’s mental health difficulties.<sup>1254</sup> The incident reporting form invited the reporting youth worker to select the option ‘the young person was incited/provoked by other young person/s’ under the heading ‘moderating factors’, but this was not selected.<sup>1255</sup>

We have reviewed the CCTV footage of this incident, which does not contain audio.<sup>1256</sup> We consider the CCTV footage matches the account provided in the incident report prepared after the incident, except as noted next.

Immediately before the incident, Ray displayed signs of stress or anxiety. These included signs that the Centre’s psychologist had identified to Operations Management at the beginning of Ray’s admission.<sup>1257</sup> The incident report stated that each of the three staff members present attempted to stop the incident by speaking to the three young people but that the incident did not end until three more staff members arrived after a ‘code black’ was called.<sup>1258</sup> It is not apparent from the CCTV footage that any staff member attempted to de-escalate or redirect Ray—for example, by moving him away from other young people—as he began to show signs of distress before the incident. We accept, however, that it was difficult to understand any verbal de-escalation techniques staff might have used without audio available to us.

The arrival of extra staff members cannot be seen in the CCTV footage and appears to have happened outside the room. The CCTV shows that one of the three original staff members eventually intervened to redirect Ray out of the room and away from the incident. It is unclear from the footage why that staff member took several minutes to act in this way, especially when he appears to have finally acted without support or

help from other staff. We were concerned to see that none of the original staff members present appeared to try to remove, restrain or redirect any of the three young people during lulls in the incident, including one instance where Albert left the room entirely (before returning to engage in the incident again). Alysha told us that immediately following the incident involving the three young people:

... I spoke to Patrick Ryan and [the then Acting Manager, Professional Services and Policy] about the need to report the assault to the police as well as the need to get Ray medically assessed. They insisted that it was a ‘fight’ between residents and that no police notification was required. He was not assessed by a doctor, nor was this attack reported to the police.<sup>1259</sup>

Alysha believed Ray was concussed, did not attend school due to the concussion and did not get medical care.<sup>1260</sup>

The Nurse Unit Manager’s notes from 2 January 2020 in relation to Ray indicate that ‘[n]il signs of concussion noted ... and author advised [Ray] that if he experienced any of these symptoms to notify staff immediately’.<sup>1261</sup> We are unclear whether Ray required any more help or got any further medical assistance.

The incident reports for each of Finn, Albert and Ray include a note that referral to police may be ‘pending’, but no further comments are made about when or if a referral would occur.<sup>1262</sup> Ms Honan told us the incident was not reported to police ‘[d]ue to [Ray’s] mental health condition and that he was the instigator of this assault and other less serious unprovoked assaults towards detainees’.<sup>1263</sup>

### **Finding—Ray’s (a pseudonym) placement in the Franklin Unit at Ashley Youth Detention Centre in December 2019 was inappropriate and exposed him to preventable harm**

Although there was no evidence before us that Ray was subjected to harmful sexual behaviours at Ashley Youth Detention Centre, he was involved in a physical altercation.

We are concerned that Ray was placed in the Franklin Unit in the first place and then not moved once concerns were raised. We hold these concerns because the Centre was aware of:

- Ray’s vulnerabilities as outlined by the Centre’s psychologist on Ray’s admission to the Centre
- concerns raised by the Multi-Disciplinary Team about the decision to place Ray in the Franklin Unit

- the harmful sexual behaviours of detainees in the Franklin Unit, particularly Albert and Finn, which at the time of Ray’s placement in the unit had not been properly addressed
- Ray ‘keeping to himself’ in the Franklin Unit, which could suggest Ray did not feel safe.

We acknowledge the evidence that Ray’s behaviour made him a risk to other detainees and that placing Ray in the Franklin Unit with Albert and Finn was the ‘least worst’ option. However, while we acknowledge that placement decisions at Ashley Youth Detention Centre likely involve a range of difficult decisions, we are not convinced that appropriate consideration was given to Ray’s ongoing safety in the Franklin Unit.

It is not apparent to us that the Centre considered transferring Ray to another unit under Very Close Supervision—the options appeared to be seen as Ray either being in a different unit or in the Franklin Unit under a Very Close Supervision order. We note that after the incident Ray was moved to another unit.

We are also not convinced that the Very Close Supervision order—which we understand to have related only to Ray’s movements in outdoor areas of the Centre—was enough to ensure Ray’s safety if he remained in the Franklin Unit. Having reviewed the CCTV footage of the incident between Ray, Albert and Finn, it does not appear that any youth worker was assigned to supervise Ray inside on that day. More appropriate supervision may have helped avoid the incident.

We are also concerned that Albert and Finn, who appeared to present similar threats to Ray, were not on Very Close Supervision orders.

At our public hearings, Ms Honan agreed the harm that Ray suffered in the incident was entirely preventable.<sup>1264</sup> She also acknowledged there ‘could have been other strategies put in place to reduce the likelihood of [the incident] occurring’.<sup>1265</sup> We agree and further consider that earlier de-escalation and intervention to stop the incident once it began would have minimised the degree of harm Ray suffered.

### **3.2.33 3 January 2020—The Centre Support Team discusses the incident involving Ray, Albert and Finn**

Staff logs and minutes of an Interim Centre Support Team meeting held the day after the 2 January 2020 incident say that Ray was moved to another unit on the night of the incident.<sup>1266</sup> A later issues briefing to the Secretary stated that Ray was moved from the Franklin Unit on 2 January 2020 in response to a different incident of property damage the day before the incident.<sup>1267</sup> According to the Ashley Youth Detention Centre daily roll, Ray was not moved to the new unit until a day later (3 January 2020), suggesting that

he spent another night in the Franklin Unit immediately after the incident.<sup>1268</sup> We do not know the reason for the discrepancy in these records, but they appear to be an example of inconsistent and poor record keeping at the Centre.

The minutes of the 3 January 2020 Interim Centre Support Team meeting state:

- ‘Staff spoke to residents involved [in the incident in the Franklin Unit] and all agreed that it was over and they were happy to move forward’.
- ‘[Ray] stated that he wished to stay in [the new unit] and it was decided that he could stay on the terms that there were no problems otherwise he would return to Franklin’.
- ‘[Albert] and [Finn] both met with [Ray] separately for mediation ... and they were all happy to move on from this’.
- Ray was told that ‘if he wished to move back to Franklin at any stage that he was welcome to do so’.<sup>1269</sup>

Albert, Finn and Ray’s involvement in the incident was classified as a detention offence and all three young people attended conferences in the days after the incident.<sup>1270</sup>

It is not clear to us whether the detainees’ individual circumstances, including Ray’s mental health condition, were considered when determining an outcome for these young people.

### **3.2.34 3 January 2020—A staff member meets with the Director, Strategic Youth Services to discuss concerns about Ashley Youth Detention Centre**

Alysha told us she met with Ms Honan again on 3 January 2020 to discuss her concerns about the Centre’s management of harmful sexual behaviours and Ray’s safety.<sup>1271</sup>

On 6 and 7 January, following this meeting, Alysha emailed Ms Honan copies of Multi-Disciplinary Team meeting minutes in which concerns about Franklin Unit placements were raised, along with a copy of the psychologist’s letter to Mr Ryan of November 2020 in which the psychologist highlighted the risk of placing vulnerable people in the Franklin Unit.<sup>1272</sup>

### **3.2.35 5 January 2020—Ray attempts to escape from Ashley Youth Detention Centre**

Three days after the incident involving Albert and Finn, Ray climbed an internal fence in an apparent attempt to escape from the Centre.<sup>1273</sup> We understand that Ray was still the subject of a Very Close Supervision order at that time, requiring a youth worker to be within five metres of Ray while he was outside a locked building.<sup>1274</sup>

The Operations Coordinator on shift, Chester (a pseudonym), emailed the Operations Manager about the incident.<sup>1275</sup> Chester reported that Ray was stopped, ‘walked back’ to his unit ‘unassisted’ and was placed in isolation for 30 minutes.<sup>1276</sup> A decision was made to place Ray on ‘unit bound’ until the next day’s Centre Support Team meeting.<sup>1277</sup> We discuss the practice of ‘unit bound’ in Case study 3. According to Chester’s email, this incident immediately followed an earlier one involving Ray, in which he attempted to steal something from an out-of-bounds area.<sup>1278</sup>

In response to a notice to produce, the Department provided us with a copy of what appears to be a complete bundle of all incident reports relating to Ray for the relevant period.<sup>1279</sup> In that bundle, we received a copy of the incident report about the earlier incident.<sup>1280</sup> We have not been provided with a copy of the incident report relating to the escape attempt or associated isolation documents. It is unclear why we did not receive a copy of the incident report and associated isolation documents relating to this incident. This is concerning because we received allegations that staff tackled and handcuffed Ray.<sup>1281</sup>

Alysha told us she spoke to Ray after he returned to the unit.<sup>1282</sup> She recalled that Ray told her he had tried to escape because ‘no-one was keeping him safe.’<sup>1283</sup>

### **3.2.36 6 January 2020—The Centre Support Team discusses the incident involving Ray, Albert and Finn**

A Centre Support Team meeting was held four days after the 2 January 2020 incident involving Albert, Finn and Ray.<sup>1284</sup> In relation to Ray, the minutes record that Ray ‘is always apologetic after incidents’ and notes that work was underway to refer Ray’s case to a Senior Quality and Practice Advisor.<sup>1285</sup> The minutes note that Ray had been ‘unit bound’ since his escape attempt the day before but do not record a decision to remove him from ‘unit bound’ at that time.<sup>1286</sup> In relation to Finn and Albert, the minutes record separately for both of them that ‘[he] has had a great week aside from the one incident that let his week down’.<sup>1287</sup>

The Centre’s psychologist was present at this meeting.<sup>1288</sup> We have viewed an email sent by a Case Management Coordinator and a member of the Centre Support Team, in the days following this Centre Support Team meeting. In that email, the Case Management Coordinator raised his concerns about how the psychologist’s presence was managed.<sup>1289</sup> We understand that some members of the Centre Support Team requested the psychologist’s presence because her expertise was required in relation to Ray in particular.<sup>1290</sup> The email recorded that Maude initially declined to allow the psychologist to attend, but when Centre Support Team members ‘insisted’, Maude agreed on the condition that the psychologist only listen and not speak.<sup>1291</sup> The email also recorded that Mr Ryan agreed with the approach.<sup>1292</sup> Alysha’s evidence was also that the psychologist had been allowed to attend on the condition that she not contribute to the discussion.<sup>1293</sup>

We asked Maude for her response to the allegation that she prevented the psychologist from contributing to the Centre Support Team meeting.<sup>1294</sup> Maude did not respond to our request for a statement.

### **3.2.37 6 January 2020—A referral is prepared to engage a Senior Quality and Practice Advisor**

Also on 6 January 2020, Mr Ryan requested that Ray be referred to a Senior Quality and Practice Advisor.<sup>1295</sup> It appears that Ms Honan either approved or directed that a referral be prepared.<sup>1296</sup>

On the same day that Mr Ryan instructed the Case Management Coordinator to prepare a referral to the Senior Quality and Practice Advisor, Alysha emailed Ms Honan requesting a meeting to discuss the incident between Ray, Albert and Finn, and the associated response.<sup>1297</sup> The email said the Multi-Disciplinary Team had ‘strongly advised against’ placing young people who were ‘highly vulnerable, suggestable and at risk’ in the Franklin Unit, ‘for their own safety’.<sup>1298</sup> The email also notified Ms Honan of Ray’s escape attempt, which had occurred when Ray was under Very Close Supervision.<sup>1299</sup> Alysha queried the value of making a referral to a Senior Quality and Practice Advisor when previous recommendations about Ray had not been followed.<sup>1300</sup>

Ms Honan’s response to Alysha was that Mr Ryan had asked Ms Honan for her ‘opinion about engaging a [Senior Quality and Practice Advisor] ... because [staff] were at a loss as to how to manage [Ray]’.<sup>1301</sup> Ms Honan suggested that a referral to the Senior Quality and Practice Advisor would ‘shine a light on the adverse responses to the advice of the Professional services staff to the [Operations] Managers’.<sup>1302</sup> We understand Alysha also spoke with a member of the Senior Quality and Practice Advisor team, who shared a similar view to Ms Honan about how a referral could assist with the internal dynamics at the Centre.<sup>1303</sup>

In her emails with Ms Honan of that day, Alysha continually expressed her serious concerns about disregard for the advice of the Professional Services Team and the Multi-Disciplinary Team and failure to comply with policy, including the following:

- Staff were not following the Multi-Disciplinary and Professional Services Teams’ advice about how to manage Ray (contrary to the suggestion that staff were simply ‘at a loss’ about how to manage Ray).<sup>1304</sup>
- Decisions to place Ray and others in the Franklin Unit were directly contrary to advice, and the incident between Ray, Finn and Albert would not have occurred had Multi-Disciplinary Team recommendations been followed.<sup>1305</sup>



- Operational staff had failed to comply with the terms of the Very Close Supervision order, enabling Ray to attempt an escape in the days following the incident with Finn and Albert.<sup>1306</sup>
- The Centre’s psychologist had been instructed not to speak at the Centre Support Team meeting in relation to next steps for Ray.<sup>1307</sup>

We understand that the Centre’s psychologist reported the incident to Child Safety Services four days after the incident.<sup>1308</sup> The report was made in conjunction with other reports the psychologist made involving Albert and Finn (as discussed earlier).<sup>1309</sup> Specifically, the psychologist reported that Ray had significant mental health difficulties and was placed with Albert and Finn contrary to recommendations.<sup>1310</sup> The psychologist also reported that the response from youth workers was ‘very delayed’ and that multiple workers were present during the incident but did not intervene.<sup>1311</sup>

The psychologist also raised the matter as part of a broader report of issues to her line manager in the Department (which we discuss further in this case study).

### 3.2.38 7 January 2020—A management plan is developed for Ray

After the 2 January 2020 incident involving Ray, Albert and Finn, Ms Honan ‘formally instructed’ Mr Ryan to ask Alysha (in consultation with the psychologist) to ‘set out clear strategies to manage [Ray] and also develop some recommendations’.<sup>1312</sup> This was to occur in conjunction with the referral to the Senior Quality and Practice Advisor.<sup>1313</sup>

On 7 January 2020, Mr Ryan instructed Digby, the Manager, Professional Services and Policy, to prepare a management plan for Ray.<sup>1314</sup>

Ray’s final management plan, prepared by Digby, provided that:

- Ray was to remain in a specified unit (not the Franklin Unit) ‘for the time being’ and that the psychologist and others were to be consulted ‘if practicable’ before a placement decision affecting Ray was made (such as adding others to his unit).<sup>1315</sup>
- Ray was to remain under Very Close Supervision ‘until determined otherwise by both [the Multi-Disciplinary Team] and [the Centre Support Team]’.<sup>1316</sup>
- Operations staff were ‘to be reminded of their responsibilities’ in relation to Very Close Supervision, given Ray’s escape attempt.<sup>1317</sup>
- Alysha was to prepare a referral to a Senior Quality and Practice Advisor and provide operational staff with ongoing clinical support.<sup>1318</sup>

Much of the management plan covered recommendations from the psychologist working directly with Ray, which had already been raised with Centre staff at the beginning of Ray’s admission and which were listed in his existing care plan.<sup>1319</sup> The management plan also provided that a behaviour chart was to be developed—a task that the psychologist

had undertaken to complete in the days following Ray's admission.<sup>1320</sup> We understand from minutes of a Multi-Disciplinary Team meeting approximately 10 weeks after Ray's admission that the behaviour chart was to be 'reintroduced' for Ray, suggesting its use had been discontinued.<sup>1321</sup> We are unclear about whether its use was intended for a short period or what kind of use Centre staff made of it.

We asked Digby about the 2 January 2020 incident and the responses to it, including the referral to the Senior Quality and Practice Advisor. He responded that he knew 'nothing about this matter'.<sup>1322</sup> This is surprising given his role in preparing the management plan in response to the incident.

### **3.2.39 8 January 2020—The Centre Support Team again discusses the incident involving Ray, Albert and Finn**

On 8 January 2020, another Interim Centre Support Team meeting was held to discuss Ray, Albert and Finn.<sup>1323</sup>

In relation to Albert and Finn, the minutes of that meeting state:

In the follow up from this incident, both boys participated well in mediation and gave assurances that this behaviour will not occur again. During [Case Plan Review] both residents accepted their part in the incident. Conferencing will take place with all three residents involved in the incident. [The psychologist] and [Alysha] in consulting with staff post incident believe that there was considerable provocation from [Finn] and [Albert] in the lead up to the incident, but these details were not recorded on incidents for [the Centre Support Team]. Following discussion, it was felt that both [Finn] and [Albert] remain red until next [week's] [Centre Support Team meeting] as they still pose a risk with their subversive/inciting behaviour.<sup>1324</sup>

In relation to Ray, the minutes noted he was still an escape risk.<sup>1325</sup> A decision was made at the Interim Centre Support Team meeting to remove him from 'unit bound' (which we understand he had been since 5 January 2020, amounting to four days' 'unit bound') in the interests of his mental health.<sup>1326</sup> Ray was instead placed on an 'individual program with operational staff taking him outside, one-on-one, with no other residents in the yard ... when [staff] can operationally schedule it'.<sup>1327</sup> As described in the section on isolation (Case study 3), we are concerned that 'unit bound' and 'individual programs' of this kind amount, in effect, to an isolation practice. We were not provided with details of Ray's individual program as described here and remain unconvinced the individual program was any more supportive of Ray's mental health difficulties than being 'unit bound'. Ray remained under Very Close Supervision.<sup>1328</sup>

### **3.2.40 8 January 2020—A staff member reports concerns about the response to harmful sexual behaviours to the Director, Strategic Youth Services**

On 8 January 2020, an Ashley Youth Detention Centre staff member emailed Ms Honan with concerns about the culture and practices at the Centre.<sup>1329</sup> The email stated: ‘I would take this information to the Manager of Ashley; however I feel that my concerns will be overlooked’.<sup>1330</sup> In particular, this staff member outlined their concerns that Albert and Finn continued to engage in sexualised acts against young people, which had been ‘minimised by Patrick Ryan to the point where staff and other residents are now at risk of these two young people’.<sup>1331</sup>

The staff member also expressed concern that Operations Team staff and Mr Ryan were ignoring case management and the Centre’s psychologist, which was placing the ‘centre in danger’.<sup>1332</sup> Ms Honan responded on the same day, saying the information would be taken into consideration.<sup>1333</sup>

### **3.2.41 January 2020—The Ashley Youth Detention Centre psychologist informs the Department of Health about the poor response to the behaviours of Albert and Finn**

In the months before and throughout January 2020, there were many communications and meetings between the Centre’s psychologist and her superiors in the Department of Health about the operation of Ashley Youth Detention Centre.<sup>1334</sup>

The psychologist informed her superiors of her various concerns about bullying at the Centre, her professional opinion being ignored (therefore putting children and young people in detention at risk) and the poor management of Albert and Finn’s behaviours.<sup>1335</sup> There were also several communications among her superiors at the Department of Health and between the Director of Nursing and Mr Ryan about those issues.<sup>1336</sup>

In various correspondence, Department of Health staff expressed or were reported to have expressed the following views about the psychologist’s communications:

- The psychologist had never worked in a custodial setting and had inadvertently got people offside by ‘explain[ing] the bullying which has been occurring’.<sup>1337</sup>
- The psychologist was a ‘guest’ in the custodial setting at Ashley Youth Detention Centre.<sup>1338</sup>
- Placement of young people is an ‘operational issue’.<sup>1339</sup>

The Nurse Unit Manager told us that working at Ashley Youth Detention Centre as a health practitioner is not the same as working in the community or any other correctional facility.<sup>1340</sup>

On 13 January 2020, staff from the Department of Health met with the Centre’s psychologist to explain the differences between working in a custodial setting and working in the community.<sup>1341</sup> The Nurse Unit Manager and Mr Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us there were no specific policies and procedures for Department of Health employees working at Ashley Youth Detention Centre.<sup>1342</sup> We note there has been no specific custodial training provided to Department of Health staff working at the Centre.<sup>1343</sup>

The former Head of Department, Forensic Mental Health Services, Department of Health, explained to us that Department of Health staff are not employees of Ashley Youth Detention Centre and are limited in the performance of their duties while in the prison system.<sup>1344</sup> They said the reality is that custodial staff may refuse to accept medical advice because custodial staff have overall responsibility for children and young people in detention and ensuring the good operation of the Centre.<sup>1345</sup>

Secretary Pervan confirmed that the then Department of Communities retained the ‘overall responsibility’ for the health, safety and welfare of young people at the Centre during the relevant period.<sup>1346</sup> This is reflected in the memorandum of understanding between the Department and Correctional Primary Health Services.<sup>1347</sup>

### **3.2.42 Observations—Department of Health’s response to concerns of harmful sexual behaviours**

We are concerned the Department of Health did not attach enough weight to the issues raised by the Centre’s psychologist about the safety of children and young people in detention.

The response to the psychologist’s concerns appeared to focus on the role of the psychologist and the Department of Health staff in the Centre, rather than recognising:

- her expertise in harmful sexual behaviours
- the fact that young people in the Centre were displaying these behaviours
- there was a need to protect other children.

We saw little evidence of advocacy from Department of Health staff for the safety of children.

While we accept that the then Department of Communities was ultimately responsible for the operations of the Centre over this period, we consider this a lost opportunity to respond to the concerning behaviours of Albert and Finn.

### 3.2.43 20 January 2020—The Secretary is briefed on concerns regarding Ray

Approximately three weeks after the incident between Ray, Albert and Finn, Kathy Baker, who was the Acting Secretary of the then Department of Communities for a short period at that time, signed off on an issues briefing to the Secretary titled ‘Concern for Ashley Youth Detention Centre (AYDC) resident [Ray] due to recent incidents’.<sup>1348</sup> Mr Ryan prepared the issues briefing, which was cleared through Ms Honan and Mandy Clarke, Deputy Secretary, Children and Youth Services, Department of Communities.<sup>1349</sup>

The issues briefing:

- noted Ray’s mental health difficulties and health history<sup>1350</sup>
- briefly noted ‘recent’ incidents involving Ray, including the incident involving Albert and Finn and the escape attempt<sup>1351</sup>
- stated work was ‘underway to identify the triggers and management of [Ray] leading up to and during these incidents, with a referral being made for a Senior Quality and Practice Advisor review’<sup>1352</sup>
- stated that Ray was moved to the Franklin Unit for operational reasons over the period when the incident involving Albert and Finn occurred<sup>1353</sup>
- stated that the Manager, Professional Services and Policy, had prepared an updated management plan for Ray, which became operational in the week after the incident involving Albert and Finn<sup>1354</sup>
- clarified that before the updated management plan, Ray was the ‘subject of standard management’ through the Centre Support Team, Multi-Disciplinary Team and Case Plan Review<sup>1355</sup>
- stated that Ray was being ‘closely monitored and well supported by the on-site Psychologist and Professional Services Team. [Ray] will be reviewed again at [a Centre Support Team meeting] on 20 January 2020 unless an earlier review is required in the interim’.<sup>1356</sup>

The issues briefing did not acknowledge that:

- Professional Services and Health Team staff had raised several concerns about Ray since his admission to the Centre
- moving Ray to the Franklin Unit, and exposing him to Albert and Finn, was contrary to the advice of both the Professional Services Team and the Multi-Disciplinary Team
- while invited to attend Centre Support Team meetings that focused on considering and responding to Ray’s behaviours, the psychologist had been actively prevented from taking part in those meetings
- the Senior Quality and Practice Advisor referral was intended to specifically identify failures by Centre staff to follow clear recommendations about Ray’s care.

As described above, each of these issues was known within Ashley Youth Detention Centre and the Department at the time the issues briefing was prepared.

Ms Honan told us the purpose of the issues briefing was to outline the complexity of Ray's needs and behaviour and the revised management approach for Ray given the escalation of incidents. She said the matters above were not expressly raised in the issues briefing as they were yet to be analysed and assessed as part of the Senior Quality and Practice Advisor referral relating to Ray.<sup>1357</sup> This is consistent with what Ms Baker told us about her understanding of the issues briefing's purpose.<sup>1358</sup>

While we accept the purpose of the issues briefing guided its content, we are concerned it did not, on the face of it, provide all relevant context for the concerns regarding Ray.

The 'Secretary's notation' on the signed copy of the issues briefing records the following:

1. Thank you for the briefing and the ongoing care provided to [Ray], which is being managed on the advice of the Professional Services Team.
2. What is the timeframe for the [Senior Quality and Practice Advisor] review to be completed?
3. With a possible discharge date of 18 March 2020, can we please start preparing for [Ray's] release and ongoing care for his condition outside of [Ashley Youth Detention Centre]<sup>1359</sup>

Given the issues briefing was signed off by Ms Baker, we understand this comment was not prepared or approved by Secretary Pervan.

### **Finding—The 20 January 2020 issues briefing on concerns regarding Ray at Ashley Youth Detention Centre was inadequate and incomplete**

We are concerned the issues briefing to the Secretary about Ray, dated 20 January 2020, gave the impression that Ray's behaviours had only begun to escalate immediately before the issues briefing and that Centre staff had acted in a timely fashion to address issues in a manner consistent with the Professional Services Team's advice.

The briefing did not inform the Secretary that the Centre had been on notice of potential harm due to Ray's vulnerabilities and the previous behaviours of Albert and Finn. It did not notify the Secretary that this potential harm eventuated in the 2 January 2020 incident.

Further, we are concerned the intended scope of the Senior Quality and Practice Advisor referral—being the need to identify and address breakdowns in internal processes and procedures that had caused recommendations of the Multi-Disciplinary Team and psychologist to be ignored—was not made explicit.

### **3.2.44 28 January 2020—Ashley Youth Detention Centre engages a Senior Quality and Practice Advisor**

Ms Honan approved the involvement of a Senior Quality and Practice Advisor, and the Quality Improvement and Workforce Development Team was advised of this, approximately four weeks after the incident involving Ray, Albert and Finn.<sup>1360</sup>

Ms Honan told us the Senior Quality and Practice Advisor's review began in February 2020 but was not completed because of a restructure of the Quality Improvement and Workforce Development Team, staff redeployment and the outbreak of COVID-19.<sup>1361</sup>

### **3.2.45 19 March 2020—The Serious Events Review Team reports its findings and recommendations about the 7 August 2019 incident involving Henry**

The Serious Events Review Team's report on the 7 August 2019 incident involving Henry, Albert and Finn was completed in March 2020.<sup>1362</sup> There were more than 25 findings in the review team's report, which covered decision making, incident management, supervision and support of children and young people in detention, communication, document and file management, workplace culture and staff support, training and supervision, and staffing resources.

The Serious Events Review Team's key findings were:

- There was 'disagreement and conflict' among staff about the seriousness of the incident.<sup>1363</sup>
- The incident in question 'constituted a sexual assault' of Henry.<sup>1364</sup>
- The incident should have been urgently reported to police and Child Safety Services, consistent with best practice principles, legislation and the Department's guidelines.<sup>1365</sup>
- Decision making in relation to the consequences for the offending child or young person in detention was 'flawed and inconsistent with best practice principles, legislation and Departmental guidelines'.<sup>1366</sup>
- There were several issues concerning the completion of incident reports, including a lack of detail and critical information, and no evidence of review or approval as required by internal policy.<sup>1367</sup> The Serious Events Review Team concluded that such failings had 'the potential to expose the staff and young people to an increased risk of harm and the wider service system to internal and external criticism and a loss of credibility'.<sup>1368</sup>
- The Centre Support Team's meeting minutes and the issues briefing provided to the Secretary did not 'accurately portray the incident and, consequently, minimised its severity and indicated a concerning lack of understanding of sexual assault and its possible consequences'.<sup>1369</sup>



- Conferencing with Albert and Finn did not occur, which was a breach of the available guidelines and legislation.<sup>1370</sup>
- Anecdotal evidence suggested ‘the behaviour of the offenders may be impacting upon how they are managed by staff on a day to day basis which may in turn be placing residents, staff and the centre at risk’.<sup>1371</sup>
- Centre staff did not have a ‘comprehensive understanding of the issues around sexual assault’.<sup>1372</sup>
- A recommendation on Henry’s care plan that he not be placed with Albert or Finn had not been observed and, had it been, the incident would not have occurred.<sup>1373</sup>
- Albert and Finn should have been under a higher level of supervision, given their history of abusive behaviour.<sup>1374</sup>
- The use of Very Close Supervision was problematic and difficult to implement due to staff shortages and ‘differences of opinion’ among staff about when to apply it.<sup>1375</sup>
- The review experienced ‘significant difficulties’ obtaining information and interviewing staff; the ‘provision of information to the review and cooperation with the reviewers was so problematic in this case that it may have been deliberately obstructive’.<sup>1376</sup>
- Communications with executive management ‘did not accurately represent the incident and minimised the concerns which could lead to misconceptions, misunderstandings and poorly targeted and ineffective interventions’.<sup>1377</sup>
- ‘[O]pen and honest communication’ appeared to be ‘discouraged’ at Ashley Youth Detention Centre, and communications were ‘disrespectful and inappropriate’.<sup>1378</sup>
- The Centre’s filing systems were ‘inadequate, incomplete and confusing’ and did not ‘support services to young people’.<sup>1379</sup>
- There was a ‘concerning lack of training, support, debriefing and supervision of staff’ at the Centre, contributing to an ‘unacceptably high risk of psychological and actual physical harm to staff and young people’.<sup>1380</sup>
- Staffing levels were inadequate.<sup>1381</sup>
- Ashley Youth Detention Centre had a ‘toxic workplace culture ... characterised by distrust, suspicion, conflict and frustration’.<sup>1382</sup>

The Serious Events Review Team made 17 recommendations to the Department, including that the Department:

- develops a strategy to ensure all Centre staff ‘are aware of the governing legislation, policies, procedures and practices’, with a particular emphasis on mandatory reporting, record keeping, the Behaviour Development System, case management and Very Close Supervision<sup>1383</sup>
- develops ‘specific strategies to address the breaches of policy, procedure and practice that have been identified as part of the review’<sup>1384</sup>
- clarifies and/or develops the policies, procedures and staff responsibilities for moving young people to a different unit<sup>1385</sup>
- ensures there is a procedure for providing support to young people following incidents, including a mechanism for reporting and monitoring that support<sup>1386</sup>
- ensures all staff are aware of grievance procedures and avenues for support when lodging or progressing grievances<sup>1387</sup>
- reviews staff training, ‘with a focus on relevance and frequency and applicability to a trauma informed approach’<sup>1388</sup>
- urgently develops a ‘mandatory, evidence based, trauma informed training schedule’ for staff, covering (at minimum): ‘trauma informed care; child development; attachment theory; the impact of trauma on children and young people; positive behaviour management; situational risk assessment; and disability, mental health and drug and alcohol issues in children and young people’<sup>1389</sup>
- provides training to all staff in relation to understanding and responding to sexual abuse, and develops associated guidelines<sup>1390</sup>
- ensures the Children and Youth Services’ ‘formal supervision model’ is implemented at the Centre as a matter of priority<sup>1391</sup>
- develops a strategy to address the ‘identified issues related to the toxic culture that currently exists at [the Centre] as a matter of urgency’<sup>1392</sup>
- conducts an inquiry into claims made about the Franklin Unit and the management of Albert and Finn.<sup>1393</sup>

The Serious Events Review Team’s report noted that ‘the review experienced significant delays due to difficulties in accessing information and arranging interviews with relevant staff’.<sup>1394</sup>

As described earlier in this case study, it was the policy for a Serious Events Review Team report to be considered by the Serious Events Review Committee before being supplied to the Secretary. Ms Burton told us she could not recall her report being

presented to this committee.<sup>1395</sup> Ms Burton believes her report was provided directly to Ms Honan.<sup>1396</sup> Ms Burton also believes that none of the other reports she prepared following reviews of incidents at Ashley Youth Detention Centre were sent to the Serious Events Review Committee.<sup>1397</sup>

In our public hearings, Mandy Clarke, former Deputy Secretary, Children, Youth and Families, Department of Communities, explained that because the Serious Events Review Team's reviews were assessing Ashley Youth Detention Centre and were not focused on the Child Safety Services system, those reviews fell outside the terms of reference of the Serious Events Review Team.<sup>1398</sup> As such, the reviews did not follow the usual process of going to the Serious Events Review Committee.<sup>1399</sup>

There were differences in views about the formal purpose of the Serious Events Review Team. Both Ms Honan and Ms Clarke gave evidence that the Serious Events Review Team was established for the 'particular purpose' of looking into infant deaths.<sup>1400</sup>

The members of the Serious Events Review Team told us that it was established not only to review child deaths but also to review serious injury and near misses across the Division of Children and Families within the Department, including Ashley Youth Detention Centre, and to make recommendations for improving service delivery.<sup>1401</sup>

The former Deputy Secretary for Children, Ginna Webster, who set up the Serious Events Review Team, also told us that its purpose, as directed by her, was to review incidents at Ashley Youth Detention Centre as well as elsewhere within Child Safety Services.<sup>1402</sup>

Secretary Pervan agreed with Ms Clarke's distinction between official Serious Events Review Team reviews and other reviews conducted by members of the Serious Events Review Team, so it was appropriate the Serious Events Review Team report in relation to the 7 August 2019 incident was not provided to the Serious Events Review Committee.<sup>1403</sup> However, Secretary Pervan provided a different explanation for the distinction.<sup>1404</sup> He said that '[b]y the time that Ms Burton was asked to undertake the review, the [Serious Events Review Team] had been disbanded or returned to their substantive positions'.<sup>1405</sup> He explained that the team was used to conduct the review in 'recognition of the [Serious Events Review Team] skills' and the reason the report took the form of a Serious Events Review Team review was 'because that was the template structure that they used'.<sup>1406</sup>

Despite expressing this view, Secretary Pervan went on to agree with Ms Burton's evidence that the Serious Events Review Team was formally dissolved in May or June 2020, after the review of the 7 August 2019 incident had concluded.<sup>1407</sup> Secretary Pervan also told us that while the Serious Events Review Team is now not a standing investigative resource for the Department, it can be reconvened if required to undertake a specific investigation or review.<sup>1408</sup>

### 3.2.46 Observations—The Serious Events Review Team review

We found the evidence about the process for considering the Serious Events Review Team review confusing. It appears there was general agreement that the Serious Events Review Team reviews relevant to Ashley Youth Detention Centre were not considered by the Serious Events Review Committee, but the reasons given for this varied.

We are concerned the Centre reviews did not go through the usual governance process. We consider this governance process important because it provides a mechanism to ensure problems are broadly acknowledged and shared, and for further accountability when addressing recommended reforms.

We discuss the disbandment of the Serious Events Review Team, and other similar incident review mechanisms, in Chapter 9.

### 3.2.47 February 2020—Reviewer raises other concerns

During her Serious Events Review Team review of the 7 August 2019 incident involving Henry, Ms Burton observed various other issues at Ashley Youth Detention Centre that were outside the terms of reference for the review. In addition to preparing the Serious Events Review Team’s report, Ms Burton sent Ms Honan memorandums outlining those other issues.<sup>1409</sup>

We have received and considered two of these memorandums, one dated 21 February 2020 and another dated 27 February 2020.<sup>1410</sup> These memorandums raise:

- concerns about a poor culture at Ashley Youth Detention Centre, including allegations of physical abuse between staff, bullying and sexual harassment<sup>1411</sup>
- allegations that the Centre’s management had refused the psychologist’s request to access the files of young people in detention<sup>1412</sup>
- alleged non-consensual sexual activity between a female young person in detention and several male young people in detention when the female in detention was housed with males<sup>1413</sup>
- an allegation of historical sexual abuse of a young person in detention by staff member Lester (a pseudonym)<sup>1414</sup>
- an allegation that Lester recently ‘strip searched’ a young person, outside the scope of his duties.<sup>1415</sup>

In addition to the above issues, Ms Burton told us she also prepared at least one memorandum for Ms Honan concerning reports that older detainees in the Franklin Unit were being used to ‘control’ younger detainees ‘by whatever means’ and that incident reports had been rewritten.<sup>1416</sup> We have not been provided with copies of any memorandums that specifically addressed the use of older detainees to control young detainees, nor any additional memorandums, despite requesting Ms Burton’s files from the State.<sup>1417</sup>

Ms Burton told us she sent all memorandums to Ms Honan by email but that she did not receive a response.<sup>1418</sup> We received evidence of at least one such email being sent in late February 2020.<sup>1419</sup>

We asked Ms Honan what action she took in response to the email and memorandum she received from Ms Burton in late February 2020. Ms Honan explained that the concerns about staff culture (including allegations of bullying and sexual harassment) had already been raised and were being investigated at the time.<sup>1420</sup> She further stated that the allegation of non-consensual sexual activity between a female and male detainees had previously been investigated.<sup>1421</sup>

In relation to allegations about Lester, Ms Honan commented that Alysha had previously reported these and they had already been referred to People and Culture at the Department. Ms Honan also told us the allegation that Lester strip searched a young person was investigated and it was found that he ‘had not acted inappropriately’.<sup>1422</sup> We discuss the Department’s response to allegations about Lester in Case study 7.

We understood Ms Honan’s response as suggesting that she considered the memorandums from Ms Burton were matters already known and that they did not require any specific follow-up (separate from processes already underway or concluded at that time).

### **3.2.48 20 May 2020—The Commissioner for Children and Young People receives the Serious Events Review Team’s report about the 7 August 2019 incident involving Henry**

Despite Commissioner McLean’s request to be kept up to date with the Serious Events Review Team’s review of the 7 August 2019 incident involving Henry, it appears she did not receive any update until 18 February 2020, when Secretary Pervan notified her that there had been delays in the Serious Events Review Team’s review due to staff absences over the Christmas and New Year period.<sup>1423</sup> Commissioner McLean received a copy of the final review report on 20 May 2020.<sup>1424</sup>

Evidence suggests that between May 2020 and January 2021, Commissioner McLean maintained regular contact with Ms Honan, Ms Clarke and Secretary Pervan, and received quarterly updates on the progress of implementing the Serious Events Review Team’s recommendations.<sup>1425</sup> After that period, there does not appear to be any further correspondence in relation to monitoring implementation until May or June 2021. In May or June 2021, Commissioner McLean was provided the ‘Response to the Findings of a Serious Event Review Team (SERT) Review in Relation to Former AYDC Resident [Henry]’ written by Stuart Watson, Centre Manager, setting out the steps the Department had taken in response to the recommendations.<sup>1426</sup>

### 3.2.49 June 2021—The Department responds to the Serious Events Review Team’s report about the 7 August 2019 incident involving Henry

Fiona Atkins, Assistant Manager at the Centre, told us she was part of the working group within Ashley Youth Detention Centre responsible for implementing the recommendations that resulted from the Serious Events Review Team’s review of the 7 August 2019 incident.<sup>1427</sup> In June 2021, more than a year after the Serious Events Review Team’s report was finalised, Mr Watson emailed Ms Honan with his final ‘response’ to the Serious Events Review Team’s findings.<sup>1428</sup>

Mr Watson explained that the delay in his response to the Serious Events Review Team review was due to him just taking over the role of Manager at Ashley Youth Detention Centre in March 2020 (which we note was more than a year before), the COVID-19 pandemic, staff shortages and more immediate priorities.<sup>1429</sup> Ms Honan attributed the delay in implementing the recommendations to the ‘interdependent’ and ‘large in scale’ nature of the recommendations, which required time to resource and sequence.<sup>1430</sup> She stated that implementation had been progressing for 13 to 16 months, but it was not until the recommendations had ‘momentum towards completion’ that Mr Watson could complete the response.<sup>1431</sup>

That response summarised how a similar incident would be managed differently and identified the following improvements made to Ashley Youth Detention Centre’s processes since the 7 August 2019 incident:

- Reports and CCTV are reviewed by the Operations Manager and then the Centre Support Team (now the Weekly Review Meeting).<sup>1432</sup>
- Case/shift notes are reviewed by Ashley Team Support (formerly Professional Services) staff and feedback provided as part of a continual improvement process.<sup>1433</sup>
- All stakeholders are now included at the conference held following an incident, and the process is facilitated by ‘experienced, qualified people that are legislatively aware’.<sup>1434</sup>
- Victim-survivors are given immediate support and post-incident follow-up to ensure safety, health and wellbeing needs are met, and they are informed of their rights to make a formal complaint.<sup>1435</sup>
- Staff are regularly rotated through all units, provided with professional supervision and enter Professional Development Agreements so they are consulted about their work preferences and the reasons behind them.<sup>1436</sup>

We are unaware if the response was provided to anyone in the Department other than Ms Honan and her Executive Officer.

Ms Honan’s evidence was that the recommendations of the review have been actioned and that she monitors their progress.<sup>1437</sup>

Ms Clarke said that ‘to the best of [her] knowledge the [Serious Events Review Team] recommendations were accepted’.<sup>1438</sup> She told us the Centre’s management team was responsible for implementing the recommendations.<sup>1439</sup> She later provided us with a Minute to the Strengthening Safeguards working group dated August 2021 that stated the last of the review’s recommendations had been implemented.<sup>1440</sup>

Secretary Pervan told us he had not received a ‘briefing on the progress of these issues’ and therefore, he did not answer some of our questions about the Serious Events Review Team, including how the Department has ensured the successful implementation of the team’s recommendations.<sup>1441</sup> Secretary Pervan told us he understood that the recommendations had been accepted and ‘integrated into wider ongoing reforms’ at Ashley Youth Detention Centre but that Ms Clarke and Ms Honan were responsible for implementing those recommendations.<sup>1442</sup>

The *Serious Event Review Team Information Sheet*, dated August 2019, stated that the Children and Youth Services Executive was responsible for implementing any recommendations of a review, and the Minister for Human Services and the Secretary were to receive monthly updates.<sup>1443</sup>

The former manager of the Serious Events Review Team told us the Department’s executive was not required or expected to report to the Serious Events Review Team on implementing recommendations.<sup>1444</sup> An undated version of the terms of reference for the Serious Events Review Committee, which the former manager of the Serious Events Review Team provided to us, stated that that committee played a role in monitoring ‘progress reporting against recommendation implementation’.<sup>1445</sup> We note however, that as discussed above, Secretary Pervan and Ms Clarke explained that reviews of Ashley Youth Detention Centre were not provided to this committee.

### **Finding—The response to the Serious Events Review Team review of the 7 August 2019 incident did not follow a clear process for implementation and oversight**

It appears there was no clear accountability or governance process for reporting against the recommendations of Serious Events Review Team recommendations concerning Ashley Youth Detention Centre. As we observe in relation to the reviews themselves, strong governance structures ensure problems are shared and acted on.



Had a clear formal oversight and accountability process been adopted, there would have been mechanisms for the Secretary and the Minister to be regularly briefed and potentially for a body like the Serious Events Review Committee to provide additional oversight.

We find that acting outside the review structures resulted in a collective lack of ownership in the Department for responding to the Serious Events Review Team's report on the 7 August 2019 incident involving Henry.

### 3.2.50 Post June 2021—Reforms are implemented in response to the Serious Events Review Team's report

Ms Honan and Mr Watson identified the following improvements made to Ashley Youth Detention Centre practice and procedure following the Serious Events Review Team report:

- A policy review working group was established, led by a senior policy officer, to revise all policies and procedures at the Centre. Finalised procedures are reflected in the electronic practice manual.<sup>1446</sup>
- Training in mandatory reporting, case note and record keeping, the Behaviour Development Plan and Very Close Supervision was updated, delivered to staff and incorporated into the induction for new staff.<sup>1447</sup>
- Case management procedures were under review and were a work in progress. In August 2022, Ms Honan told us she expected this review would be completed by the end of 2022.<sup>1448</sup>
- Moving detainees to a different unit is now determined by the 'Weekly Review Meeting' (previously the Centre Support Team), and an additional risk assessment process is followed if safety concerns arise. Ms Honan told us that the on-call manager must approve any after-hours movement of young people.<sup>1449</sup>
- Case note and incident recording is now electronic and centralised.<sup>1450</sup>
- A new therapeutic practice framework and learning and development framework have been implemented, which are designed to help staff work with young people in a trauma-informed way.<sup>1451</sup>
- Key positions that support operational roles have been reviewed and reclassified to ensure policy development, training and supervision is up to date and delivered by suitably skilled and qualified staff.<sup>1452</sup>
- Recruitment has been centralised through the People and Culture Team.<sup>1453</sup>

- There has been a change in leadership and a ‘significant focus’ on workplace behaviours.<sup>1454</sup>
- A Senior Business Partner has helped staff to proactively manage complaints and to address conflict and concerns.<sup>1455</sup>
- Security improvements have been made, including securing the courtyards for all units.<sup>1456</sup>
- Workshops have addressed low morale and the Centre’s poor workplace culture.<sup>1457</sup>

### 3.2.51 Mid-2021—Ray displays harmful sexual behaviours

It is notable that in later periods of detention at Ashley Youth Detention Centre, Ray displayed an ‘emerging pattern of sexual disinhibition’, including making ‘sexually inappropriate comments’ and engaging in ‘increased sexualised talk’.<sup>1458</sup> Eventually, staff raised concerns that he may sexually assault other young people at the Centre. We are not aware of any evidence that he did so. We are concerned, however, by evidence that Ray began displaying similar harmful behaviours in the months following his exposure to violent behaviours at the Centre. A failure to respond appropriately to harmful sexual behaviours may perpetuate the behaviour.

### 3.2.52 December 2021—Max asks to be transferred from Ashley Youth Detention Centre to adult prison

Beyond the incidents noted above, Max was also involved in other incidents at the Centre that were unrelated to harmful sexual behaviours.<sup>1459</sup> Max’s time at the Centre ended in late 2021 with him displaying continuing and increasingly challenging behaviours: ‘I just kept going and I would have code blacks called on me every day. I kept hitting staff and stuff like that’.<sup>1460</sup> Max told us he behaved this way in an effort to get transferred from the Centre to an adult prison, despite being under 18:

Well, I had— as there’d be paperwork of me trying to request to move out of there, I put in request forms, and that’s what the [Centre Support Team is] there for, and they just kept coming back saying, ‘No, you’re not going to be able to move no matter what you do’. So then that made it even worse for me, because like, I felt I had the— I should be allowed to go to an adult prison, not sit in Ashley after everything that’s happened to me.

I don’t get treated like a kid up there, so why should I be there when just, like, I’ve had so much trauma and that there I just didn’t feel like, like, it wasn’t good for me, it wasn’t good for my headspace, so I just kept releasing all my anger on all—everyone.<sup>1461</sup>

In a Department Minute to Secretary Pervan dated 22 December 2021 about the proposed transfer of Max to the adult prison system, Max’s behaviour was summarised as follows:

[Max]’s current presentation includes frequent aggressive behavioural outbursts, extensive property damage, threatening/intimidating/assaulting staff, fighting with other residents, and high levels of emotional distress.

[Max] has had 17 incident / detention offences in November and 12 as at 20 December 2021. This includes attempted staff assaults, resident assaults including an assault on a 14-year-old resident, standoffs/riotous behaviour including inciting other young people to join him on three occasions, he has attempted to access staff security equipment on several occasions.

[Max] has increased threats to include threats of sexual assault against staff and other young people including exposing himself to other young people and staff.

[Max] poses a significant risk to staff and other resident safety and cannot be adequately managed to ensure safety of staff and other residents.<sup>1462</sup>

In an email from Ms Honan to Secretary Pervan on 8 February 2022, Ms Honan wrote that Max was transferred to the adult prison system because ‘his behaviour was too complex and high risk to manage at [Ashley Youth Detention Centre]’.<sup>1463</sup> Based on Max’s evidence, the transfer appears to have been consistent with Max’s wishes and stated requests at the time. However, we were also told that Max had been experiencing high levels of emotional distress during this period and frequently changed his mind regarding the transfer.<sup>1464</sup>

Max told us that when he was transferred to adult prison, Ashley Youth Detention Centre staff told him it was his Christmas present.<sup>1465</sup>

A memorandum of understanding between the former Department of Health and Human Services (Children and Youth Services) and Department of Justice (Tasmanian Prison Service) executed in December 2014 governs and facilitates the transfer of young people between the Centre and the Tasmania Prison Service. This memorandum of understanding, which remains in effect, enabled Max’s transfer.<sup>1466</sup>

### **3.2.53 Early 2022—Max asks to be transferred from adult prison back to Ashley Youth Detention Centre**

It appears that in early 2022, when he was still under the age of 18, Max asked to return to Ashley Youth Detention Centre.<sup>1467</sup> As part of that process, Max contacted the Commissioner for Children and Young People, Leanne McLean, to advocate for his request.

Commissioner McLean wrote to Secretary Pervan on 17 March 2022, outlining Max’s experiences in the adult prison system.<sup>1468</sup> Max had reported to Commissioner McLean that he was being exposed to long periods of isolation, was self-harming (which resulted in further restrictions on his movement) and was being housed with a large number of adults.<sup>1469</sup> Commissioner McLean also noted Max’s desire to attend Ashley School.<sup>1470</sup>

Commissioner McLean asked Secretary Pervan that Max be allowed to return to the Centre.<sup>1471</sup> Commissioner McLean noted that she was ‘not supportive’ of Max’s transfer to the adult prison system when the original decision was made.<sup>1472</sup> Secretary Pervan responded to Commissioner McLean’s email on 20 March 2022, writing that ‘it is my determination that the information provided does not mitigate the significant risk that [Max] continues to present to the safety of other young people and staff at [Ashley Youth Detention Centre]’.<sup>1473</sup>

On 22 March 2022, in response to Secretary Pervan’s determination, Commissioner McLean made the following comment about the apparent inability of Ashley Youth Detention Centre to manage or address the challenging behaviours of a young person like Max:

Thank you for informing me of your decision that [Max] will remain at the [Tasmanian Prison Service], and the information influencing your decision. It is unfortunately an indication of the limitations of our current model, that these types of behaviours cannot be responded to in an appropriate therapeutic fashion within a youth-specific environment.<sup>1474</sup>

Commissioner McLean also asked Secretary Pervan for more information about Max’s circumstances, including:

- how he would communicate the determination to Max, and inform Max whether he could seek a review of the decision through the Ombudsman
- what measures were being taken to ensure Max’s wellbeing in the adult prison system, raising her concerns as to ‘who is responsible for the wellbeing of a child remanded to an adult facility’
- how the decision to remand Max in the adult prison system was made following his earlier arrests, subsequent to his initial transfer from Ashley Youth Detention Centre.<sup>1475</sup>

We asked Secretary Pervan about his decision not to allow Max to return to Ashley Youth Detention Centre once Max was detained in an adult prison, and his response to Commissioner McLean’s other queries of 22 March 2022 about how Max would be provided with the appropriate therapeutic supports if he remained in adult prison. Secretary Pervan presented us with his email response to Commissioner McLean, dated 26 April 2022, more than a month after she sent him her queries. Secretary Pervan’s email made the following points:

- He had assumed that Commissioner McLean, as Max’s advocate, would inform Max of the determination not to transfer Max back to Ashley Youth Detention Centre and any rights he had to review that decision.

- Max’s wellbeing in the adult prison system was being supported by visits from his Community Youth Justice Worker and Child Safety Officer, the therapeutic services offered by the Tasmania Prison Service, as well as information provided by Ashley Youth Detention Centre authorities to the Tasmania Prison Service about Max, such as his ‘trigger points and associated behaviour management strategies’.
- Upon Max’s previous arrest and him being remanded in custody, Secretary Pervan had formed the opinion that it was not practicable to detain Max at Ashley Youth Detention Centre based on the factors considered when Max was first transferred to the adult prison system.<sup>1476</sup>

Secretary Pervan acknowledged the limitations of Ashley Youth Detention Centre to be able to address the needs of children with complex needs and stated that the issue was ‘being taken into account in the design of the new facilities that will replace [Ashley Youth Detention Centre]’.<sup>1477</sup>

### **Finding—Ashley Youth Detention Centre was not equipped to meet the complex needs of children and young people, resulting in at least one young person being transferred to adult prison**

Ashley Youth Detention Centre should be able to meet the needs of children displaying complex behaviours. It was not able to in early 2022, resulting in at least one young person being detained in adult prisons.

We remain concerned about how the needs of young people in detention are being met now, given Secretary Pervan’s indication that the complex needs of children and young people are being considered in the design for the new facility, which has not yet been built. It is unacceptable that the solution to a young person displaying challenging behaviours in youth detention is to transfer that young person to an adult prison, where they face further risk of sexual abuse.

Max’s specific circumstances are complicated somewhat by his admitted desire for such a transfer in late 2021 and his stated intention to escalate his behaviour to compel that outcome. However, once he requested a transfer back to Ashley Youth Detention Centre after experiencing the adult prison system—while still a minor—the Centre should have been in a position to manage and meet Max’s needs. In addition, any opportunity for Max to improve his behaviour and receive therapeutic care at Ashley Youth Detention Centre should have been properly assessed.

### 3.2.54 Observations—Harmful sexual behaviours displayed by Albert and Finn

Ashley Youth Detention Centre was aware that Albert had displayed harmful sexual behaviours as early as January 2018, 17 months before the 7 August 2019 incident with Henry.<sup>1478</sup> Records of multiple other incidents involving Albert and Finn, while not investigated in detail, suggest their behaviours were frequent and persistent and indicated a need for specialist treatment.<sup>1479</sup>

In addition, the Centre was notified, on multiple occasions by different staff, that not enough was being done to manage Albert's and Finn's harmful sexual behaviours and the risks these behaviours posed to other detainees, including Henry:

- On 13 August 2019, Ms Gardiner and the union delegate raised concerns that the Centre's response to the 7 August 2019 incident involving Henry was inappropriate.
- On 22 August 2019, Ms Gardiner advised that she was reporting the incident to Child Safety Services.
- On 18 September 2019, the Ashley Youth Detention Centre psychologist raised concerns about Henry being placed in a program with Finn, given Finn's harmful sexual behaviours towards Henry on 7 August.
- On 13 November 2019, the psychologist again raised her concerns about Albert and Finn's behaviours in an email.
- On 15 November 2019, the psychologist once more raised her concerns in a letter.
- On 6 December 2019, the psychologist advised that she had made mandatory reports to Child Safety Services and the Commissioner for Children and Young People.

Even when attempts were made to address the behaviours of Albert and Finn, these were not progressed. We are concerned that Alysha and the psychologist's review into the behaviours of Albert and Finn was quashed, seemingly by Centre management.

When asked about the management of Albert and Finn, a Case Management Coordinator at the Centre told us:

They weren't managed appropriately because the senior decision makers were completely dysfunctional. One simple thing that would have helped was to separate [Albert and Finn] as they were a poor influence on each other.<sup>1480</sup>

Ms Gardiner stated that not addressing the needs of Albert and Finn 'placed them at risk for being perpetrators of future sexual assault. [Ashley Youth Detention Centre] had a responsibility for rehabilitation for the detainees, and this was not addressed'.<sup>1481</sup>

In her evidence, Ms Honan expressed concern with the failure of Centre management to act on the advice of Ms Gardiner and the psychologist, saying ‘these were highly skilled practitioners, why their advice was disregarded is not okay’.<sup>1482</sup>

Some staff at Ashley Youth Detention Centre raised serious concerns about harmful sexual behaviours, as well as other harmful behaviours, at the Centre. We were concerned that other staff at the Centre did not appear to appreciate the seriousness of Albert and Finn’s behaviour and the risk they posed to other children (and staff) and to members of the community after their release if they were not rehabilitated. We also query why Centre staff did not consider moving Albert and/or Finn out of the Franklin Unit.

### **3.2.55 Observations—The Department of Communities’ response to allegations about placement decisions**

As described in this case study, we received evidence that the Centre and the Department were made aware of allegations that older detainees were being used to threaten younger detainees. Specifically:

- The psychologist emailed Mr Ryan on 13 November 2019 advising that a young person had reported to her they had been threatened with placement in the Franklin Unit and that detainees get ‘stood-over, abused and raped’ in that unit.<sup>1483</sup>
- Ms Burton told us she reported the matter to Ms Honan by a memorandum prepared during her review of the 7 August 2019 incident.<sup>1484</sup>
- Ms Honan acknowledged that Alysha reported the matter to her.<sup>1485</sup>

We asked Ashley Youth Detention Centre management and Department officials about the evidence from former Centre staff that misbehaving detainees had been threatened with transfers to the Franklin Unit so their behaviour could be ‘sorted out’.<sup>1486</sup>

In his statement to us, Mr Ryan did not answer our question about whether there was, at any time, a practice of using placement decisions to threaten or punish children or young people detained at the Centre.<sup>1487</sup> He did state that he was not aware of any perception among children or young people in detention that they would not be protected against the risk of sexual abuse in the Franklin Unit until the Centre’s psychologist told him.<sup>1488</sup>

Mr Watson could not comment on practices before starting work at the Centre in 2020.<sup>1489</sup> He said that a policy or practice of using older detainees to control or influence younger detainees was not presently in use, and he agreed any such practice or policy would be ‘totally inappropriate’.<sup>1490</sup>

In response to our question about whether there was a policy or practice of using some young people in detention as a threat to influence or punish the conduct of other detainees (particularly in relation to the Franklin Unit), Mr Brown told us that ‘[f]rom



memory the [Behaviour Development System] and induction processes were the only policies used to assess where residents were placed'.<sup>1491</sup>

Ms Clarke also told us she had no knowledge of any practice of using placement decisions to punish children or young people in detention.<sup>1492</sup> She confirmed that such conduct 'would warrant a formal investigation'.<sup>1493</sup>

Secretary Pervan denied knowledge of any policy of Centre staff threatening young people with a placement in the Franklin Unit.<sup>1494</sup> He stated that he had not been made aware of concerns with placement decisions until receiving a request for statement from us on 2 August 2022.<sup>1495</sup>

Ms Honan told us she became aware of the possibility of such a practice after Alysha raised the matter with her in late 2019. As described here, Ms Burton told us that during her investigation of the 7 August 2019 incident, she raised with Ms Honan reports that older detainees in the Franklin Unit were being used to 'control' younger detainees.<sup>1496</sup>

Ms Honan said that this issue formed part of the terms of reference of the Serious Events Review Team and Senior Quality and Practice Advisor reviews.<sup>1497</sup> We note that the Senior Quality and Practice Advisor review was never completed and the referral does not raise the issue of using children and young people in detention in the Franklin Unit as a control mechanism.<sup>1498</sup> We are unsure which Serious Events Review Team review Ms Honan was referring to, but note that the terms of reference of the review in relation to the Henry incident in August 2019 did not refer to the allegations that older detainees were used to control or threaten younger detainees.

### **Finding—The Department should have fully investigated allegations that staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees**

We are concerned that the allegation that some staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees has not been fully investigated, despite this concern first being raised with Centre management in late 2019 and being subsequently raised with Department staff. We would have expected such an investigation to speak to children and young people in detention and staff about their views, particularly children and young people's sense of safety. We remain concerned that some staff who are the subject of those allegations may still be working at Ashley Youth Detention Centre.

### 3.2.56 6 May 2022—A new unit placement procedure is put in place

In a statement provided to us, dated 27 July 2022, Secretary Pervan attached a copy of the *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* ('Unit Placement Procedure').<sup>1499</sup> The new Unit Placement Procedure acknowledges that decisions about unit placement are 'critical, as placement decisions can affect a young person's health and wellbeing by either increasing or decreasing the risk of immediate or future harm'.<sup>1500</sup> The following 'critical requirements' are identified in the policy to 'ensure the safety of young people':

All new arrivals will be housed in the admission induction unit.

Male and female detainees will be housed separately. Detainees that identify as transgender will guide their unit placement.

If deemed safe, young people from Aboriginal and Torres Strait Islander backgrounds should room share.

Placement decisions about young people must be made in the best interests of all young people at the Centre.<sup>1501</sup>

We note that the new policy does not refer to harmful sexual behaviours or more broadly that safety should be a paramount consideration in placement decisions. We also consider that the policy lacks clarity on what 'operational considerations' may warrant decisions about unit placement and is generally unclear as to who has what power to make a placement decision in any given context (and who is required to review or may override such a decision). In Chapter 12, we discuss this policy, the importance of clear responsibility for decision making in placing children and young people in detention and the importance of clinically-led responses to safety concerns.

#### **Finding—There is a lack of consistent policy and practice at Ashley Youth Detention Centre on unit placements**

There continues to be a lack of clear policy and practice around placement decisions and unit moves at Ashley Youth Detention Centre, including who is responsible for the final decision and reviewing any decision.

This lack of clear process is concerning when children are displaying harmful behaviours and may cause a threat to the safety and wellbeing of other children and young people in the Centre.

There should be clear ultimate decision-making responsibility for placement decisions, which should consider the risks posed by young people who display harmful sexual behaviours.

### 3.3 System observations—Max, Henry and Ray

It was apparent to us that systemic problems at Ashley Youth Detention Centre contributed to the risk of harmful sexual behaviours among detainees, as well as the failure to appropriately respond when these risks are realised. Combined, the treatment of Max, Henry and Ray—particularly their unit placements—highlighted several systemic problems. We discuss some of these earlier in the case study. Here we focus on others.

#### 3.3.1 Lack of thorough assessment, including risk assessment

It is our view that many staff at Ashley Youth Detention Centre failed to appreciate the risks to Max, Henry and Ray. Consequently, Max, Henry and Ray were subjected to what we consider to be predictable and therefore, avoidable incidents of significant harm.

Henry's placement in the Franklin Unit with Albert and Finn should not have happened given that staff knew Albert and Finn had ongoing and prolonged histories of harmful sexual behaviours. Max's placement in the Franklin Unit should not have happened given that staff were aware that Henry had recently been subjected to harmful sexual behaviours by Albert and Finn. Given Ray's clearly recorded mental health condition on his admission to the Centre, his mental health difficulties over his first months in detention and the escalation in his behaviours in the lead-up to his transfer to the Franklin Unit, Ray should not have been placed with Albert and Finn, who were known to engage in aggressive and violent behaviours.

No risk assessments were undertaken by operational staff with decision-making authority for placements about the suitability of the Franklin Unit for Max, Henry and Ray before these young people were placed in that unit. Rather, where risks had been identified by professional services staff, these were not given appropriate weight. Other operational considerations seem to have influenced the decisions about Max, Henry and Ray's placements.

#### 3.3.2 Staff tensions

It was also apparent to us that tensions between staff and/or teams hindered collaborative decision making about the safety of detainees, which, if addressed, could have significantly mitigated the risks to Max, Henry and Ray.

We observed, on the evidence before us, a dysfunctional relationship or a culture of professional disregard between some operational staff on the one hand and some professional staff on the other hand, particularly during 2019 and early 2020. One staff member described the relationship between some teams as 'caustic'.<sup>1502</sup> We heard of allegations of professional staff being invited to attend meetings but not being allowed to speak. We observed a range of instances where some expert staff recommendations were ignored or their involvement in managing vulnerable detainees was explicitly

denied by both operational staff and management. This meant decisions were being made without consultation and in contradiction to professional advice. In our view, this placed children and young people in detention at risk of sexual harm and ultimately contributed to the harm caused to Max, Henry and Ray. We are concerned that some of these staff tensions reflected a broader divide among staff about the philosophical approach to youth detention and whether a corrections or therapeutic focus was preferable.

The influence of Department employees, including the psychologist, was limited by and subject to the operational decisions of Ashley Youth Detention Centre staff, which prevented concerns about harmful sexual behaviours from being escalated further and prevented clinically-led decision making necessary for a therapeutic response.

We consider the psychologist's repeated reports as indicative of her professional concern. We are concerned that her attempts to raise concerns appear to have been met with a lack of care.

We are also troubled by the alleged conduct of some staff towards other staff who raised concerns about harmful sexual behaviours, including unprofessional conduct, silencing, finger pointing and dismissiveness.

### **3.3.3 Capacity to identify and respond to harmful sexual behaviours**

It was apparent to us that some Ashley Youth Detention Centre staff lacked capacity to recognise and respond to harmful sexual behaviours between detainees. We consider that all staff should receive training on harmful sexual behaviours, particularly senior decision-makers.

If the response of Centre staff to incidents of harmful sexual behaviour is not therapeutic or trauma-informed, problems for young people, staff and the Centre as a whole, now and into the future, will continue with devastating consequences.

Max's experiences at Ashley Youth Detention Centre highlight the ongoing cost of the Centre's failure to meaningfully identify and address harmful sexual behaviours. When Max's long history at the Centre is viewed holistically, we can see that he has become caught in a cycle of trauma and abuse. The 2018 Serious Events Review Team's report into the harmful sexual behaviours Max experienced, while seemingly prepared by the investigator with diligence and in good faith, somewhat and perhaps unintentionally downplayed incidents that caused significant distress to Max. The broad outcome appears to have been a lack of appreciation for the harm caused to Max and an affirmation of the limited response by Centre staff to those incidents. Shortcomings in the response to Max's experiences of harmful sexual behaviours appear to have contributed to Max using violence and harmful sexual behaviours against others.

It is disappointing and concerning that there were seemingly no therapeutic responses available to address the behaviours of Max within the youth custodial context. This is apparently the case despite the best efforts of individuals to have such therapeutic capacity built within the institutional context of the Centre.

### 3.3.4 Serious Events Review Team

It appears that the Serious Events Review Team's investigation into the incident involving Henry, although delayed, eventually led to several improvements to the Centre's information systems, security systems and responses. These included:

- centralising and digitising incident reporting
- improvements to risk assessments for after-hours unit moves
- improvements to staff training for incident reporting and mandatory reporting obligations.

We note that without that investigation, the actions and decisions of Centre staff regarding harmful sexual behaviours would not have been scrutinised and challenged. The Serious Events Review Team's investigation highlights the importance of having a permanent, experienced and skilled investigative team available to the Department for when serious incidents occur. We note the importance of young people participating in decisions that affect them, including in investigations, is consistent with international obligations and child safe standards.

## 4 Recent reforms

Ms Honan told us that harmful sexual behaviours would be managed differently if they were to occur at Ashley Youth Detention Centre today. She told us that:

- Placement decisions are now subject to a risk assessment and are more thoroughly scrutinised at Weekly Review Meetings.<sup>1503</sup>
- The Advice and Referral Line would be notified (Ms Honan did not clarify who would make the notification).<sup>1504</sup>
- Clinical staff would better protect and support victim-survivors.<sup>1505</sup>
- There would be a referral to police (Ms Honan did not clarify who would make the notification, but Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, told us that referrals are made to police 'upon the assessment of the [Centre Support Team] with the [Centre] Manager's support').<sup>1506</sup>
- Incidents involving harmful sexual behaviours would be referred to the Sexual Assault Support Service.<sup>1507</sup>

- Post-management of an incident would be more comprehensive and centralised with the Ashley Incident Management System. All electronic notes and witness statements would be quality assured by the Operations Coordinator and reviewed by the Assistant Manager before being forwarded to the Manager and Director.<sup>1508</sup>
- Staff are now better able to address the behaviours of the kind presented by Albert and Finn due to the current Behaviour Development Program.<sup>1509</sup>
- There is greater support for Operations Team staff from managers and practitioners in relation to enforcing boundaries and reinforcing pro-social behaviours.<sup>1510</sup>
- A Risk Assessment Process Team would be convened to provide recommendations, practical support and advice in managing risk.<sup>1511</sup>
- The Director would be informed about all incidents involving harmful sexual behaviours.<sup>1512</sup>
- All incidents would be reviewed by the Commissioner for Children and Young People and the Custodial Inspector.<sup>1513</sup>
- Young people engaging in harmful sexual behaviours would be referred to services and safety precautions would be placed around them.<sup>1514</sup>

Ms Honan also stated that staff at Ashley Youth Detention Centre would be supported to:

... call out and address not placate intimidating behaviours. Focus on rewarding positive behaviours when they do occur using the changes within the [Behaviour Development Program] system would have been used to incentivise change. Improvements to incident management reporting and the quality and detail of information now contained in [Weekly Review Meeting] minutes further safeguard the minimisation of incidents and under reporting of them.<sup>1515</sup>

Secretary Pervan told us that where a young person is subjected to harmful sexual behaviours by another young person, they are ‘supported therapeutically’ by the onsite nurse, medical officer and psychologist, and the young person’s care plan is updated and overseen by the Multi-Disciplinary Team.<sup>1516</sup> That said, we received information that the position of onsite psychologist at the Centre has not been filled since November 2021.<sup>1517</sup> Secretary Pervan did not confirm whether mental health support is offered to a young person engaging in harmful sexual behaviours. He did state that Ashley School provides programs on healthy relationships, consent and sexual decision making.<sup>1518</sup>

The Nurse Unit Manager told us that in the event of an incident of harmful sexual behaviour, she would ensure Ashley Youth Detention Centre staff were ‘aware’ and that ‘conferencing is scheduled to address the behaviours of concern’.<sup>1519</sup> She also stated that longer term supports through services such as family planning would be enlisted to ‘tailor the delivery of a safe sex education session, which cover aspects of healthy sexual relationships and behaviour, as well as legal boundaries (such as consent)’.<sup>1520</sup>

Ms Honan acknowledged that Ashley Youth Detention Centre is only in the early stages of adopting trauma-informed practice.<sup>1521</sup> Her evidence was that the concept is understood by staff but ‘the breakdown is probably in having the skillset and the clinical oversight and guidance about working with that’.<sup>1522</sup> We received evidence from Ms Atkins that Operations Team staff still lack the training, skill and resources to respond to and manage young people displaying harmful sexual behaviours.<sup>1523</sup>

Despite that information regarding the current practice for responding to incidents of harmful sexual behaviour at the Centre, we also received information that the functions and powers of the Commissioner for Children and Young People to review such incidents is limited, and entirely dependent on being notified of such incidents.<sup>1524</sup> Commissioner McLean informed us she has not been formally contacted by the Department to review any harmful sexual behaviour incidents at the Centre, despite making requests to be notified of such incidents.<sup>1525</sup> Further, Commissioner McLean told us that, in situations where she has provided feedback to the Centre and the Department about the way an incident of harmful sexual behaviour has been or should be handled, she is generally not provided with a response to such feedback by the Centre or the Department.<sup>1526</sup> Notably, in a recent instance where Commissioner McLean was contacted by a young person regarding an incident of harmful sexual behaviour at the Centre, she requested advice from the Department in late April 2023 regarding measures taken in response to this incident, however, as at 11 July 2023, had not received a response from the Department.<sup>1527</sup>

## 5 Harmful sexual behaviours—2022–23

In early 2023, the Tasmanian Legislative Council was conducting its Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters. Some submissions to that inquiry raised concerns about, among other things, the behaviours of detainees, staff safety and the lack of a clear understanding of therapeutic and trauma-informed care, and questioned if it was appropriate for a detention setting.<sup>1528</sup> In particular, two submissions we read were by retired police officers who had answered a call in late 2022 to work at Ashley Youth Detention Centre to address immediate staffing shortages. They described similar concerns. One described the challenging behaviours of young people in the Centre this way:

Indecent assaults are common practice with resident on resident fondling and touching and resident on youth worker touching. There were many times where I asked a resident if they wished to make a complaint—the answer was always similar, ‘just playing, joking around (normally an expletive), just having fun’. Of the many sexual contacts I witnessed, resident on resident, not one complaint was made.



In my case I was touched on the breasts on occasions and being asked ‘if I liked it’, being touched on the backside and in other sexual ways. I was frequently being asked about my sexual activity the night before and on one occasion and in front of other residents and a youth worker (female) a resident asked ‘if I liked it up the bum’.

The resident was severely chastised by the other youth worker and me and, as was a common practice, said ‘can’t you take a joke’. This was the similar response in all inappropriate touching—‘only joking’.

I witnessed many vicious assaults—resident on resident and resident on youth worker.<sup>1529</sup>

While not described as such in the submission, this is a description of harmful sexual behaviours. It echoes, for us, comments made in the 2018 Serious Events Review Team report, which said inappropriate sexual behaviour by children and young people in detention ‘must be managed on a daily basis’ in the Centre and noted that ‘it may be useful to consider expert review, advice and [ongoing] consultation concerning this issue to support [the Centre] to assist residents to develop socially appropriate behaviours for transition to the community’.<sup>1530</sup>

We are concerned these sexualised behaviours may have become normalised within the Centre.

### **Finding—Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these**

While this case study has focused heavily on events from 2018 to 2022, and identified specific failings in relation to those events, we are concerned that these events and the response of the Centre and the Department echo a pattern across many years at Ashley Youth Detention Centre.

We heard too many accounts, from as early as the 2000s, of children and young people being harmed by the sexualised behaviours of other detainees, sometimes facilitated by, or with the knowledge or implicit approval of, staff.

At times staff have failed to respond to known risks of harm, allowing vulnerable children and young people to be placed with or exposed to young people who pose a risk to their safety.

When harmful sexual behaviours did occur, staff or Centre management often failed to respond appropriately—whether by not removing the risks, not supporting the victim-survivor, or punishing them for making a complaint. When some staff raised concerns about the risk of harm to certain children or young people in detention, those concerns were sometimes not given appropriate weight within the culture and operations of the Centre.

We hold serious concerns about allegations that, at times, staff have used unit placement or threats of unit placement with other detainees known to display violence and harmful behaviours to threaten, intimidate or control more vulnerable children and young people.

# Notes

## Introduction to case studies

- 1 *Royal Commission into Institutional Responses to Child Abuse* (Final Report, December 2017) vol 2, 166.
- 2 The names ‘Alysha’ and ‘Max’ are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 3 Michael Ferguson and Jacque Petrusma, ‘Rebuilding Tasmania’s Health and Human Services System’ (Media Release, 28 October 2015) <[https://www.premier.tas.gov.au/releases/rebuilding\\_tasmanias\\_health\\_system2](https://www.premier.tas.gov.au/releases/rebuilding_tasmanias_health_system2)>; Roger Jaensch and Jacque Petrusma, ‘Department of Communities Tasmania’ (Media Release, 9 May 2018) <[https://www.premier.tas.gov.au/releases/department\\_of\\_communities\\_tasmania](https://www.premier.tas.gov.au/releases/department_of_communities_tasmania)>; Will Hodgman, ‘Changes to Senior Public Service Management’ (Media Release, 21 August 2019) <[https://www.premier.tas.gov.au/releases/changes\\_to\\_senior\\_public\\_service\\_management](https://www.premier.tas.gov.au/releases/changes_to_senior_public_service_management)>; ‘About Us’, Department of Communities (Web Page, undated) <<https://www.communities.tas.gov.au/about-us>>; Peter Gutwein, ‘Department Structures to Strengthen Tasmanian Outcomes’ (Media Release, 22 February 2022) <[https://www.premier.tas.gov.au/site\\_resources\\_2015/additional\\_releases/department\\_structures\\_to\\_strengthen\\_tasmanian\\_outcomes](https://www.premier.tas.gov.au/site_resources_2015/additional_releases/department_structures_to_strengthen_tasmanian_outcomes)>.
- 4 Peter Gutwein, ‘Department Structures to Strengthen Tasmanian Outcomes’ (Media Release, 24 February 2022) <[https://www.premier.tas.gov.au/site\\_resources\\_2015/additional\\_releases/department\\_structures\\_to\\_strengthen\\_tasmanian\\_outcomes](https://www.premier.tas.gov.au/site_resources_2015/additional_releases/department_structures_to_strengthen_tasmanian_outcomes)>.
- 5 Statement of Michael Pervan, 23 August 2022, 16–17 [58].
- 6 Statement of Ginna Webster, 29 April 2022, 1 [7], 2 [8].
- 7 Statement of Ginna Webster, 29 April 2022, 1 [6–7].
- 8 Statement of Mandy Clarke, 19 August 2022, 1.
- 9 Statement of Mandy Clarke, 19 August 2022, 1.
- 10 Statement of Mandy Clarke, 19 August 2022, 1.
- 11 Statement of Kathy Baker, 18 August 2022, 1–2.
- 12 Statement of Kathy Baker, 18 August 2022, 1.
- 13 Statement of Kathy Baker, 18 August 2022, 1.
- 14 Statement of Greg Brown, 28 November 2022, 1 [3–4].
- 15 Statement of Jacqueline Allen, 15 August 2022, 2 [17]–3 [18].
- 16 Statement of Jacqueline Allen, 15 August 2022, Annexure C (‘People and Culture Organisational Structure’, May 2020); Statement of Jacqueline Allen, 15 August 2022, Annexure F (‘People and Culture structure’, undated).
- 17 Statement of Greg Brown, 28 November 2022, 1 [3–4].
- 18 Statement of Pamela Honan, 18 August 2022, 1 [1.1].
- 19 Transcript of Pamela Honan, 19 August 2022, 2935 [9–21].
- 20 Transcript of Mandy Clarke, 25 August 2022, 3397 [41–45].
- 21 Statement of Pamela Honan, 16 November 2022, 10 [6.1]; Statement of Greg Brown, 28 November 2022, 2 [5].
- 22 Transcript of Patrick Ryan, 7 September 2022, 3568 [36–40]; Statement of Stuart Watson, 16 August 2022, 1 [1–2], [10].
- 23 Statement of Stuart Watson, 16 August 2022, 1 [10].
- 24 Statement of Pamela Honan, 16 November 2022, 10 [4.1].

## Case study 1: The nature and extent of abuse in Ashley Youth Detention Centre

- 25 Refer to, for example, Statement of ‘Ben’, 29 March 2022, 4 [18]; Statement of ‘Max’, 19 May 2022, 2 [7–11]; Transcript of ‘Charlotte’, 24 August 2022, 3202 [22–33]; Statement of ‘Charlotte’, 31 January 2022, 2; Statement of ‘Oscar’, 29 July 2022, 2 [6].

- 26 Notice to produce served on the State of Tasmania, 20 July 2021.
- 27 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 1 produced by the Tasmanian Government in response to a Commission notice to produce.
- 28 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 3. The Claims of Abuse in State Care Program is also sometimes referred to as the Tasmanian Abuse in State Care Ex Gratia Scheme.
- 29 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 4.
- 30 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 3.
- 31 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 3.
- 32 Department of Justice, 'Response to NTP-TAS-0004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 33 Ombudsman Tasmania, *Listen to the Children: Review of Claims of Abuse from Adults in State Care as Children* (Report, November 2004) 15.
- 34 Ombudsman Tasmania, *Listen to the Children: Review of Claims of Abuse from Adults in State Care as Children* (Report, November 2004) 16.
- 35 Ombudsman Tasmania, *Review of Claims of Abuse from Adults in State Care as Children* (Final Report – Phase 2, June 2006) 5.
- 36 Ombudsman Tasmania, *Review of Claims of Abuse from Adults in State Care as Children* (Final Report – Phase 2, June 2006) 3, 6.
- 37 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 3.
- 38 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 10.
- 39 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 14.
- 40 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 41 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 42 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 8.
- 43 Statement of the Department for Education, Children and Young People, 20 January 2023, Annexure 40(B) ('Claims of Abuse in AYDC', Spreadsheet, 19 September 2020), produced by the Tasmanian Government in response to a Commission notice to produce.
- 44 Department of Justice, 'Response to NTP-TAS-0004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 45 Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 46 Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

- 47 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 48 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 49 Statement of Michael Pervan, 7 June 2022, 19 [118].
- 50 Statement of Michael Pervan, 7 June 2022, 19 [121].
- 51 Statement of Michael Pervan, 7 June 2022, 19 [119].
- 52 Statement of Michael Pervan, 14 June 2022, 98 [537].
- 53 Statement of Michael Pervan, 14 June 2022, 97 [535].
- 54 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 55 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'NTP-TAS-04 – Item 19 Response', 4 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 56 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 57 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 58 'About the National Redress Scheme', National Redress Scheme (Web Page) <<https://www.nationalredress.gov.au/about/about-scheme>>.
- 59 Statement of Michael Pervan, 7 June 2022, 18 [112].
- 60 Statement of Michael Pervan, 7 June 2022, 18 [114]; Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information Relating to Claims under the National Redress Scheme', Procedure, Children and Youth Services) 1.
- 61 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 62 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 63 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 64 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 65 Statement of Michael Pervan, 27 July 2022, 86 [343].
- 66 Statement of Michael Pervan, 27 July 2022, Annexure 27 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated). In Chapter 17, we note that, as at 8 April 2022, 689 National Redress Scheme claims had been made in relation to Tasmanian Government institutions.

- 67 Statement of Michael Pervan, 27 July 2022, Annexure 77 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated); Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 68 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 69 Statement of Michael Pervan, 27 July 2022, 86 [343]; Statement of Michael Pervan, 27 July 2022, Annexure 77 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated).
- 70 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 71 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 72 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 73 Statement of Michael Pervan, 27 July 2022, Annexure 77 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated).
- 74 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 75 Statement of Michael Pervan, 27 July 2022, Annexure 77 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated).
- 76 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 77 Statement of Michael Pervan, 27 July 2022, Annexure 77 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated); Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 78 Department of Communities, 'Briefing to Minister for Children and Youth: Employment Matters at Ashley Youth Detention Centre (AYDC)', 4 November 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 79 'AYDC Class Action', *Angela Sdrinis Legal* (Web Page) <<https://www.angelasdrinislegal.com.au/aydc-class-action.html>>; Amber Wilson, 'Ashley Abuse Action: Dozens More Join Lawsuit', *The Mercury* (online, 25 February 2023) 8 <[gandmmonitoring.com.au/reports/story.php?storyProfileID=732722](https://www.gandmmonitoring.com.au/reports/story.php?storyProfileID=732722)>.
- 80 'AYDC Class Action', *Angela Sdrinis Legal* (Web Page) <<https://www.angelasdrinislegal.com.au/aydc-class-action.html>>.
- 81 Submission 086 Angela Sdrinis Legal, 48.
- 82 Submission 086 Angela Sdrinis Legal, 59.
- 83 Submission 086 Angela Sdrinis Legal, 60.
- 84 Submission 086 Angela Sdrinis Legal, 60.
- 85 Submission 086 Angela Sdrinis Legal, 60.
- 86 Submission 086 Angela Sdrinis Legal, 60.
- 87 Department of Communities, 'Summary of Complaints Received by the Department in relation to Ashley Youth Detention Centre' (Spreadsheet), 9 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

- 88 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 89 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 90 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 91 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 92 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 93 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 94 Statement of 'Ben', 29 March 2022, 1–2 [5].
- 95 Statement of 'Ben', 29 March 2022, 2 [6–7].
- 96 Statement of 'Ben', 29 March 2022, 2 [8].
- 97 Statement of 'Ben', 29 March 2022, 2 [9].
- 98 Statement of 'Ben', 29 March 2022, 2 [9].
- 99 Statement of 'Ben', 29 March 2022, 2 [9].
- 100 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 1.
- 101 Statement of 'Ben', 29 March 2022, 3 [10].
- 102 Statement of 'Ben', 29 March 2022, 3 [10].
- 103 Statement of 'Ben', 29 March 2022, 3 [11].
- 104 Statement of 'Ben', 29 March 2022, 3 [11].
- 105 Statement of 'Ben', 29 March 2022, 4 [18].
- 106 Statement of 'Ben', 29 March 2022, 6 [27]; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 1.
- 107 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 1.
- 108 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 1.
- 109 Statement of 'Ben', 29 March 2022, 6 [27].
- 110 Statement of 'Ben', 29 March 2022, 6 [27].
- 111 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 112 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2, 4.
- 113 Statement of 'Ben', 29 March 2022, 4 [18].
- 114 Statement of 'Ben', 29 March 2022, 4 [18].
- 115 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 116 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 117 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 118 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.



- 119 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 120 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 121 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 122 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 123 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 124 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3.
- 125 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.
- 126 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4. The name 'Stan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 127 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.
- 128 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.
- 129 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.
- 130 Statement of 'Ben', 29 March 2022, 5 [22]; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 131 Statement of 'Ben', 29 March 2022, 5 [22].
- 132 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 133 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 6.
- 134 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 6.
- 135 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 6.
- 136 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 6.
- 137 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 6.
- 138 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 7.
- 139 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 7.
- 140 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 7–8.
- 141 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 7–8.
- 142 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.

- 143 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 144 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 145 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 146 Statement of 'Ben', 29 March 2022, 6–7 [28]; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 147 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2.
- 148 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2–3.
- 149 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 150 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 151 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 152 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 153 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 5.
- 154 Statement of 'Ben', 29 March 2022, 5–6 [25].
- 155 Statement of 'Ben', 29 March 2022, 7 [32].
- 156 Statement of 'Ben', 29 March 2022, 7 [32].
- 157 Statement of 'Ben', 29 March 2022, 6 [26].
- 158 Statement of 'Ben', 29 March 2022, 6 [26].
- 159 Statement of 'Ben', 29 March 2022, 4 [18–19].
- 160 Statement of 'Ben', 29 March 2022, 4 [19].
- 161 Statement of 'Ben', 29 March 2022, 5 [20].
- 162 Statement of 'Ben', 29 March 2022, 5 [20].
- 163 Statement of 'Ben', 29 March 2022, 8 [33].
- 164 Statement of 'Ben', 29 March 2022, 8 [33].
- 165 Statement of 'Ben', 29 March 2022, 8 [34].
- 166 Statement of 'Ben', 29 March 2022, 8 [35–36].
- 167 Statement of 'Ben', 29 March 2022, 8 [37].
- 168 Statement of 'Ben', 29 March 2022, 8 [38].
- 169 Statement of 'Ben', 29 March 2022, 9 [39].
- 170 Statement of 'Ben', 29 March 2022, 9 [39].
- 171 Statement of 'Ben', 29 March 2022, 9 [41].
- 172 Statement of 'Ben', 29 March 2022, 10 [44–45].
- 173 Statement of 'Ben', 29 March 2022, 10 [47].
- 174 Statement of 'Ben', 29 March 2022, 10 [47].
- 175 Statement of 'Ben', 29 March 2022, 10 [48].
- 176 Statement of 'Ben', 29 March 2022, 10 [48].
- 177 Statement of 'Ben', 29 March 2022, 10 [49].
- 178 Statement of 'Ben', 29 March 2022, 11 [50].

- 179 Statement of 'Ben', 29 March 2022, 11 [51].
- 180 Statement of 'Ben', 29 March 2022, 11 [51].
- 181 The names 'Eve' and 'Norman' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Eve', 18 August 2022, 1 [4–5]; Transcript of 'Eve', 19 August 2022, 2868 [40–42], 2869 [32–41].
- 182 Transcript of 'Eve', 19 August 2022, 2869 [4–8].
- 183 Transcript of 'Eve', 19 August 2022, 2869 [22–26].
- 184 Statement of 'Eve', 18 August 2022, 1 [3].
- 185 Statement of 'Eve', 18 August 2022, 2 [6]; Transcript of 'Eve', 19 August 2022, 2870 [38–45].
- 186 Statement of 'Eve', 18 August 2022, 2 [6]; Transcript of 'Eve', 19 August 2022, 2870 [38–45].
- 187 Statement of 'Eve', 18 August 2022, 2 [7].
- 188 Statement of 'Eve', 18 August 2022, 2 [8]; Transcript of 'Eve', 19 August 2022, 2871 [45].
- 189 Statement of 'Eve', 18 August 2022, 2 [9].
- 190 Statement of 'Eve', 18 August 2022, 2 [9]; Transcript of 'Eve', 19 August 2022, 2871 [4–9].
- 191 Statement of 'Eve', 18 August 2022, 2 [9]; Transcript of 'Eve', 19 August 2022, 2871 [4–9].
- 192 Statement of 'Eve', 18 August 2022, 5 [27].
- 193 Statement of 'Eve', 18 August 2022, 2 [9].
- 194 Transcript of 'Eve', 19 August 2022, 2873 [27–41]; Statement of 'Eve', 18 August 2022, 3 [14].
- 195 Statement of 'Eve', 18 August 2022, 3 [17].
- 196 Statement of 'Eve', 18 August 2022, 3 [17]–4 [19].
- 197 Statement of 'Eve', 18 August 2022, 5 [28].
- 198 Statement of 'Eve', 18 August 2022, 3 [16]; Transcript of 'Eve', 19 August 2022, 2872 [35]–2873 [6].
- 199 Statement of 'Eve', 18 August 2022, 4 [20–21].
- 200 Statement of 'Eve', 18 August 2022, 4 [22].
- 201 Statement of 'Eve', 18 August 2022, 4 [22–23].
- 202 Transcript of 'Eve', 19 August 2022, 2876 [2–12].
- 203 Statement of 'Eve', 18 August 2022, 4 [25].
- 204 Statement of 'Eve', 18 August 2022, 4 [25].
- 205 Statement of 'Eve', 18 August 2022, 5 [26].
- 206 Statement of 'Eve', 18 August 2022, 5 [26].
- 207 Transcript of 'Eve', 19 August 2022, 2876 [35].
- 208 Transcript of 'Eve', 19 August 2022, 2876 [35–37].
- 209 Statement of 'Eve', 18 August 2022, 7 [38].
- 210 Statement of 'Eve', 18 August 2022, 7 [37].
- 211 Statement of 'Eve', 18 August 2022, 4 [24].
- 212 Statement of 'Eve', 18 August 2022, 5 [29]–6 [34]; Transcript of 'Eve', 19 August 2022, 2873 [47]–2874 [29].
- 213 Statement of 'Eve', 18 August 2022, 7 [39].
- 214 Statement of 'Eve', 18 August 2022, 7 [40].
- 215 Statement of 'Eve', 18 August 2022, 7 [41].
- 216 Statement of 'Eve', 18 August 2022, 7 [42].
- 217 Statement of 'Eve', 18 August 2022, 7 [43].
- 218 Statement of 'Eve', 18 August 2022, 8 [44].
- 219 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 1 [3].
- 220 Transcript of 'Max', 23 August 2022, 3109 [43]–3110 [2].

- 221 Statement of 'Max', 19 May 2022, 1 [3].
- 222 Statement of 'Max', 19 May 2022, 1 [3].
- 223 Statement of 'Max', 19 May 2022, 1 [4].
- 224 The name 'Floyd' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [6].
- 225 Statement of 'Max', 19 May 2022, 2 [6].
- 226 Statement of 'Max', 19 May 2022, 2 [6].
- 227 Statement of 'Max', 19 May 2022, 2 [7].
- 228 The name 'Alan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [7–9].
- 229 Statement of 'Max', 19 May 2022, 2 [9].
- 230 Restricted publication order ('Ned'), 18 August 2022. Statement of 'Max', 19 May 2022, 2 [10–11].
- 231 Statement of 'Max', 19 May 2022, 2 [11].
- 232 Statement of 'Max', 19 May 2022, 2 [11].
- 233 Statement of 'Max', 19 May 2022, 3 [13].
- 234 Statement of 'Max', 19 May 2022, 3 [13].
- 235 Statement of 'Max', 19 May 2022, 3 [15].
- 236 Statement of 'Max', 19 May 2022, 3 [16].
- 237 Statement of 'Max', 19 May 2022, 3 [16].
- 238 Statement of 'Max', 19 May 2022, 3 [16].
- 239 The name 'Arlo' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 4 [17].
- 240 Statement of 'Max', 19 May 2022, 4 [17].
- 241 Statement of 'Max', 19 May 2022, 4 [18].
- 242 Statement of 'Max', 19 May 2022, 4 [20]; Transcript of 'Max', 23 August 2022, 3115 [27].
- 243 Statement of 'Max', 19 May 2022, 4 [20].
- 244 Statement of 'Max', 19 May 2022, 4 [20].
- 245 Statement of 'Max', 19 May 2022, 4 [21].
- 246 Statement of 'Max', 19 May 2022, 4 [21].
- 247 Statement of 'Max', 19 May 2022, 5 [22].
- 248 Transcript of 'Max', 23 August 2022, 3115 [29–34].
- 249 Transcript of 'Max', 23 August 2022, 3117 [1–12]; Statement of 'Max', 19 May 2022, 6 [28].
- 250 Statement of 'Max', 19 May 2022, 12 [52].
- 251 Statement of 'Max', 19 May 2022, 6 [28].
- 252 Transcript of 'Max', 23 August 2022, 3121 [2–15].
- 253 Transcript of 'Max', 23 August 2022, 3120 [12–16].
- 254 Statement of 'Max', 19 May 2022, 8 [36–37].
- 255 Statement of 'Max', 19 May 2022, 8 [36].
- 256 Statement of 'Max', 19 May 2022, 8 [37].
- 257 Transcript of 'Max', 23 August 2022, 3120 [9–25].
- 258 Transcript of 'Max', 23 August 2022, 3120 [12–17].
- 259 Statement of 'Max', 19 May 2022, 10 [43]; Transcript of 'Max', 23 August 2022, 3122 [45]–3123 [15].
- 260 Statement of 'Max', 19 May 2022, 10 [43]; Transcript of 'Max', 23 August 2022, 3122 [45]–3123 [15].
- 261 Statement of 'Max', 19 May 2022, 6 [27], 10 [42].
- 262 Transcript of 'Max', 23 August 2022, 3116 [8–14], 3122 [4–8].

- 263 Statement of ‘Max’, 19 May 2022, 10 [42].
- 264 Statement of ‘Max’, 19 May 2022, 6 [26].
- 265 Statement of ‘Max’, 19 May 2022, 6 [26].
- 266 Statement of ‘Max’, 19 May 2022, 10 [42].
- 267 Statement of ‘Max’, 19 May 2022, 10 [42].
- 268 Statement of ‘Max’, 19 May 2022, 6 [29]–7 [31].
- 269 Statement of ‘Max’, 19 May 2022, 7 [31].
- 270 Transcript of ‘Max’, 23 August 2022, 3123 [33–43].
- 271 Transcript of ‘Max’, 23 August 2022, 3123 [24–43].
- 272 Statement of ‘Max’, 19 May 2022, 5 [23].
- 273 Statement of ‘Max’, 19 May 2022, 5 [23].
- 274 Transcript of ‘Max’, 23 August 2022, 3119 [6–26].
- 275 Statement of ‘Max’, 19 May 2022, 5 [23].
- 276 Statement of ‘Max’, 19 May 2022, 6 [27].
- 277 Statement of ‘Max’, 19 May 2022, 7 [32].
- 278 Statement of ‘Max’, 19 May 2022, 8 [33].
- 279 Statement of ‘Max’, 19 May 2022, 8 [34].
- 280 Statement of ‘Max’, 19 May 2022, 8 [33].
- 281 Statement of ‘Max’, 19 May 2022, 8 [35].
- 282 Statement of ‘Max’, 19 May 2022, 5 [24].
- 283 Statement of ‘Max’, 19 May 2022, 12 [54].
- 284 Statement of ‘Max’, 19 May 2022, 12 [53].
- 285 Statement of ‘Max’, 19 May 2022, 12 [53].
- 286 Statement of ‘Max’, 19 May 2022, 12 [52].
- 287 The name ‘Warren’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1.
- 288 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1.
- 289 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1.
- 290 Statement of ‘Warren’, 19 May 2022, 2 [7].
- 291 Statement of ‘Warren’, 19 May 2022, 2 [7].
- 292 Statement of ‘Warren’, 19 May 2022, 2 [12].
- 293 Statement of ‘Warren’, 19 May 2022, 2 [12].
- 294 Statement of ‘Warren’, 19 May 2022, 2 [12].
- 295 Statement of ‘Warren’, 19 May 2022, 2 [8].
- 296 Statement of ‘Warren’, 19 May 2022, 2 [8].
- 297 Statement of ‘Warren’, 19 May 2022, 2 [11].
- 298 Statement of ‘Warren’, 19 May 2022, 2 [9].
- 299 Statement of ‘Warren’, 19 May 2022, 2 [10].
- 300 Statement of ‘Warren’, 19 May 2022, 2 [10].
- 301 Statement of ‘Warren’, 19 May 2022, 3 [15].
- 302 Statement of ‘Warren’, 19 May 2022, 3 [15].
- 303 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1.

- 304 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1.
- 305 Statement of ‘Warren’, 19 May 2022, 3 [15].
- 306 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 307 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 308 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 309 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 310 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 311 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 312 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 313 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 1–2.
- 314 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 315 Statement of ‘Warren’, 19 May 2022, 3 [15].
- 316 Statement of ‘Warren’, 19 May 2022, 3 [16].
- 317 Statement of ‘Warren’, 19 May 2022, 3 [16].
- 318 Statement of ‘Warren’, 19 May 2022, 3 [16].
- 319 Statement of ‘Warren’, 19 May 2022, 3 [17].
- 320 Statement of ‘Warren’, 19 May 2022, 3–4 [17].
- 321 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 322 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 323 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 324 Statement of ‘Warren’, 19 May 2022, 4 [18–19].
- 325 Statement of ‘Warren’, 19 May 2022, 4 [20].
- 326 Statement of ‘Warren’, 19 May 2022, 4 [21].
- 327 Statement of ‘Warren’, 19 May 2022, 4 [21].
- 328 Statement of ‘Warren’, 19 May 2022, 4 [22].
- 329 Statement of ‘Warren’, 19 May 2022, 4 [22].
- 330 Statement of ‘Warren’, 19 May 2022, 5 [23].
- 331 The name ‘Charlotte’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Charlotte’, 31 January 2022, 1.
- 332 Statement of ‘Charlotte’, 31 January 2022, 1.
- 333 Transcript of ‘Charlotte’, 24 August 2022, 3199 [44–45].
- 334 Statement of ‘Charlotte’, 31 January 2022, 1; Transcript of ‘Charlotte’, 24 August 2022, 3199 [45–46].
- 335 Statement of ‘Charlotte’, 31 January 2022, 1.
- 336 Statement of ‘Charlotte’, 31 January 2022, 1.



- 337 The name 'Edwin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Charlotte', 31 January 2022, 1.
- 338 Statement of 'Charlotte', 31 January 2022, 1.
- 339 Transcript of 'Charlotte', 24 August 2022, 3200 [17–23].
- 340 Statement of 'Charlotte', 31 January 2022, 1.
- 341 Statement of 'Charlotte', 31 January 2022, 1; Transcript of 'Charlotte', 24 August 2022, 3200 [13–46].
- 342 Statement of 'Charlotte', 31 January 2022, 1.
- 343 Statement of 'Charlotte', 31 January 2022, 1; Transcript of 'Charlotte', 24 August 2022, 3201 [7–8].
- 344 Statement of 'Charlotte', 31 January 2022, 1.
- 345 Statement of 'Charlotte', 31 January 2022, 1; Transcript of 'Charlotte', 24 August 2022, 3201 [10–11].
- 346 Statement of 'Charlotte', 31 January 2022, 1; Transcript of 'Charlotte', 24 August 2022, 3201 [13–21].
- 347 Transcript of 'Charlotte', 24 August 2022, 3201 [23–26].
- 348 Statement of 'Charlotte', 31 January 2022, 1.
- 349 Statement of 'Charlotte', 31 January 2022, 2.
- 350 Transcript of 'Charlotte', 24 August 2022, 3201 [29–32].
- 351 Transcript of 'Charlotte', 24 August 2022, 3201 [32–37].
- 352 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3201 [35–41], 3202 [11–13].
- 353 Transcript of 'Charlotte', 24 August 2022, 3201 [44–46].
- 354 Statement of 'Charlotte', 31 January 2022, 2.
- 355 Statement of 'Charlotte', 31 January 2022, 2.
- 356 Statement of 'Charlotte', 31 January 2022, 2.
- 357 Statement of 'Charlotte', 31 January 2022, 2.
- 358 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3202 [22–33].
- 359 Statement of 'Charlotte', 31 January 2022, 2.
- 360 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3202 [22–30].
- 361 Statement of 'Charlotte', 31 January 2022, 2.
- 362 Transcript of 'Charlotte', 24 August 2022, 3202 [35–45].
- 363 Statement of 'Charlotte', 31 January 2022, 2.
- 364 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3202 [47]–3203 [3].
- 365 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3203 [5–6].
- 366 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3203 [25–34].
- 367 Statement of 'Charlotte', 31 January 2022, 2.
- 368 Statement of 'Charlotte', 31 January 2022, 2.
- 369 Statement of 'Charlotte', 31 January 2022, 2.
- 370 Transcript of 'Charlotte', 24 August 2022, 3203 [35–39].
- 371 Statement of 'Charlotte', 31 January 2022, 3.
- 372 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3204 [32–35].
- 373 Statement of 'Charlotte', 31 January 2022, 2–3.
- 374 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3204 [35]–3205 [1], 3205 [23–35].
- 375 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3204 [37–44].
- 376 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3205 [5–14].
- 377 Statement of 'Charlotte', 31 January 2022, 3.
- 378 Statement of 'Charlotte', 31 January 2022, 3.



- 379 Statement of 'Charlotte', 31 January 2022, 3.
- 380 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3203 [13].
- 381 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [18–21].
- 382 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [18–27].
- 383 Statement of 'Charlotte', 31 January 2022, 3–4.
- 384 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [29–37].
- 385 Statement of 'Charlotte', 31 January 2022, 4.
- 386 Transcript of 'Charlotte', 24 August 2022, 3206 [40]–3207 [2].
- 387 Transcript of 'Charlotte', 24 August 2022, 3207 [5–9].
- 388 Transcript of 'Charlotte', 24 August 2022, 3204 [2–11], 3206 [40]–3207 [2].
- 389 Transcript of 'Charlotte', 24 August 2022, 3207 [12–16].
- 390 The name 'Fred' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Fred', 24 August 2022, 1 [3].
- 391 Statement of 'Fred', 24 August 2022, 1 [4–6].
- 392 Statement of 'Fred', 24 August 2022, 1 [5].
- 393 Statement of 'Fred', 24 August 2022, 1 [6].
- 394 Statement of 'Fred', 24 August 2022, 2 [7–8]; Transcript of 'Fred', 25 August 2022, 3341 [27–29].
- 395 Statement of 'Fred', 24 August 2022, 2 [9].
- 396 Statement of 'Fred', 24 August 2022, 2 [9].
- 397 Statement of 'Fred', 24 August 2022, 2 [11].
- 398 Statement of 'Fred', 24 August 2022, 2 [11].
- 399 Statement of 'Fred', 24 August 2022, 4 [21–24].
- 400 Statement of 'Fred', 24 August 2022, 4 [23]; Transcript of 'Fred', 25 August 2022, 3342 [8–14].
- 401 Statement of 'Fred', 24 August 2022, 4 [24].
- 402 Statement of 'Fred', 24 August 2022, 4 [24].
- 403 Transcript of 'Fred', 25 August 2022, 3342 [17–21].
- 404 Statement of 'Fred', 24 August 2022, 2 [12]; Transcript of 'Fred', 25 August 2022, 3342 [28–29].
- 405 Statement of 'Fred', 24 August 2022, 2 [12]; Transcript of 'Fred', 25 August 2022, 3342 [28–40].
- 406 Transcript of 'Fred', 25 August 2022, 3343 [21–26].
- 407 Statement of 'Fred', 24 August 2022, 2 [13]–3 [14]; Transcript of 'Fred', 25 August 2022, 3343 [45–46].
- 408 Statement of 'Fred', 24 August 2022, 3 [18].
- 409 Statement of 'Fred', 24 August 2022, 3 [19]; Transcript of 'Fred', 25 August 2022, 3345 [24–31].
- 410 Statement of 'Fred', 24 August 2022, 3 [16]; Transcript of 'Fred', 25 August 2022, 3345 [10–15].
- 411 Statement of 'Fred', 24 August 2022, 3 [18].
- 412 Statement of 'Fred', 24 August 2022, 5 [25].
- 413 Transcript of 'Fred', 25 August 2022, 3344 [25–30].
- 414 Statement of 'Fred', 24 August 2022, 5 [28].
- 415 Statement of 'Fred', 24 August 2022, 3 [15].
- 416 Statement of 'Fred', 24 August 2022, 5 [29–30]; Transcript of 'Fred', 25 August 2022, 3346 [17–24].
- 417 Statement of 'Fred', 24 August 2022, 5 [29].
- 418 Statement of 'Fred', 24 August 2022, 6 [32].
- 419 Statement of 'Fred', 24 August 2022, 6 [32].
- 420 Transcript of 'Fred', 25 August 2022, 3346 [47]–3347 [5].
- 421 Transcript of 'Fred', 25 August 2022, 3346 [39–44].

- 422 The name 'Oscar' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. In relation to this individual, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged. Statement of 'Oscar', 29 July 2022, 1 [3].
- 423 Statement of 'Oscar', 29 July 2022, 1 [4].
- 424 Statement of 'Oscar', 29 July 2022, 1 [5].
- 425 Statement of 'Oscar', 29 July 2022, 1 [5].
- 426 Statement of 'Oscar', 29 July 2022, 2 [6].
- 427 Statement of 'Oscar', 29 July 2022, 2 [6].
- 428 Statement of 'Oscar', 29 July 2022, 2 [6].
- 429 Statement of 'Oscar', 29 July 2022, 2 [6].
- 430 Statement of 'Oscar', 29 July 2022, 2 [8].
- 431 Statement of 'Oscar', 29 July 2022, 2 [8].
- 432 Statement of 'Oscar', 29 July 2022, 2 [9].
- 433 Statement of 'Oscar', 29 July 2022, 2 [9].
- 434 Statement of 'Oscar', 29 July 2022, 2 [7].
- 435 Statement of 'Oscar', 29 July 2022, 2 [9].
- 436 Statement of 'Oscar', 29 July 2022, 2 [9].
- 437 Statement of 'Oscar', 29 July 2022, 2 [9].
- 438 Statement of 'Oscar', 29 July 2022, 2 [10].
- 439 Statement of 'Oscar', 29 July 2022, 2 [11].
- 440 Statement of 'Oscar', 29 July 2022, 2 [11].
- 441 Statement of 'Oscar', 29 July 2022, 2–3 [11].
- 442 Statement of 'Oscar', 29 July 2022, 3 [12].
- 443 Statement of 'Oscar', 29 July 2022, 3 [12].
- 444 Statement of 'Oscar', 29 July 2022, 3 [13].
- 445 Statement of 'Oscar', 29 July 2022, 3 [13].
- 446 Statement of 'Oscar', 29 July 2022, 3 [13].
- 447 Statement of 'Oscar', 29 July 2022, 3 [13].
- 448 Statement of 'Oscar', 29 July 2022, 3 [13].
- 449 Statement of 'Oscar', 29 July 2022, 3 [14].
- 450 Statement of 'Oscar', 29 July 2022, 3 [14].
- 451 Statement of 'Oscar', 29 July 2022, 3 [15].
- 452 Statement of 'Oscar', 29 July 2022, 3 [16].
- 453 Statement of 'Oscar', 29 July 2022, 4 [17].
- 454 Statement of 'Oscar', 29 July 2022, 4 [17].
- 455 Statement of 'Oscar', 29 July 2022, 4 [17].
- 456 Statement of 'Oscar', 29 July 2022, 4 [18].
- 457 The name 'Simon' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Simon', 7 July 2022, 1 [4]–2 [7].
- 458 Statement of 'Simon', 7 July 2022, 1 [4].
- 459 Statement of 'Simon', 7 July 2022, 2 [7].
- 460 Statement of 'Simon', 7 July 2022, 2 [8].
- 461 Transcript of 'Simon', 18 August 2022, 2757 [19–20].
- 462 Transcript of 'Simon', 18 August 2022, 2757 [32–37].

- 463 Statement of ‘Simon’, 7 July 2022, 2 [9]; Transcript of ‘Simon’, 18 August 2022, 2757 [33].
- 464 Statement of ‘Simon’, 7 July 2022, 2 [9].
- 465 Statement of ‘Simon’, 7 July 2022, 2 [9].
- 466 Statement of ‘Simon’, 7 July 2022, 3 [11].
- 467 Transcript of ‘Simon’, 18 August 2022, 2758 [38–43].
- 468 Statement of ‘Simon’, 7 July 2022, 3 [11].
- 469 Statement of ‘Simon’, 7 July 2022, 3 [12].
- 470 Statement of ‘Simon’, 7 July 2022, 3 [11–12].
- 471 Transcript of ‘Simon’, 18 August 2022, 2758 [7–22].
- 472 Transcript of ‘Simon’, 18 August 2022, 2758 [17–19].
- 473 Statement of ‘Simon’, 7 July 2022, 3 [13].
- 474 Statement of ‘Simon’, 7 July 2022, 3 [13].
- 475 Transcript of ‘Simon’, 18 August 2022, 2759 [23–27], [45–46].
- 476 Statement of ‘Simon’, 7 July 2022, 3 [13].
- 477 Statement of ‘Simon’, 7 July 2022, 3 [13].
- 478 Statement of ‘Simon’, 7 July 2022, 3 [14].
- 479 Transcript of ‘Simon’, 18 August 2022, 2758 [27–31], 2759 [12–18].
- 480 Statement of ‘Simon’, 7 July 2022, 2 [7].
- 481 Transcript of ‘Simon’, 18 August 2022, 2760 [18–29].
- 482 Statement of ‘Simon’, 7 July 2022, 2 [7].
- 483 Statement of ‘Simon’, 7 July 2022, 4 [18].
- 484 Transcript of ‘Simon’, 18 August 2022, 2761 [27–39].
- 485 Statement of ‘Simon’, 7 July 2022, 4 [19].
- 486 Transcript of ‘Simon’, 18 August 2022, 2762 [34]–2763 [8].
- 487 Statement of ‘Simon’, 7 July 2022, 5 [20].
- 488 Statement of ‘Simon’, 7 July 2022, 5 [20].
- 489 Statement of ‘Simon’, 7 July 2022, 4 [16].
- 490 The name ‘Erin’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of ‘Erin’, 22 August 2022, 3018 [40]–3019 [5].
- 491 Transcript of ‘Erin’, 22 August 2022, 3019 [9–44].
- 492 Transcript of ‘Erin’, 22 August 2022, 3020 [1–10].
- 493 Transcript of ‘Erin’, 22 August 2022, 3019 [43]–3020 [10].
- 494 Transcript of ‘Erin’, 22 August 2022, 3020 [12–16].
- 495 Transcript of ‘Erin’, 22 August 2022, 3020 [18–35].
- 496 Transcript of ‘Erin’, 22 August 2022, 3020 [29–32].
- 497 Transcript of ‘Erin’, 22 August 2022, 3020 [34–39].
- 498 Statement of ‘Erin’, 18 July 2022, 6 [31]; Transcript of ‘Erin’, 22 August 2022, 3027 [5–7].
- 499 Transcript of ‘Erin’, 22 August 2022, 3020 [41–46].
- 500 Transcript of ‘Erin’, 22 August 2022, 3020 [41–47].
- 501 Transcript of ‘Erin’, 22 August 2022, 3028 [21–39].
- 502 Transcript of ‘Erin’, 22 August 2022, 3028 [22–28].
- 503 Transcript of ‘Erin’, 22 August 2022, 3028 [22–28].
- 504 Transcript of ‘Erin’, 22 August 2022, 3028 [32–45].
- 505 Transcript of ‘Erin’, 22 August 2022, 3028 [41].
- 506 Transcript of ‘Erin’, 22 August 2022, 3028 [47]–3029 [1].

- 507 Transcript of 'Erin', 22 August 2022, 3029 [1–5].
- 508 Transcript of 'Erin', 22 August 2022, 3027 [3–4].
- 509 Transcript of 'Erin', 22 August 2022, 3027 [22–25]; File note of telephone conversation from the Commission of Inquiry to 'Erin', 18 July 2023.
- 510 Transcript of 'Erin', 22 August 2022, 3027 [27–28].
- 511 Transcript of 'Erin', 22 August 2022, 3027 [4–35].
- 512 Statement of 'Erin', 18 July 2022, 6 [33]; Transcript of 'Erin', 22 August 2022, 3027 [32–33].
- 513 Statement of 'Erin', 18 July 2022, 6 [34]–7 [35]; Transcript of 'Erin', 22 August 2022, 3027 [40–41], [10–18].
- 514 Statement of 'Erin', 18 July 2022, 7 [35].
- 515 Transcript of 'Erin', 22 August 2022, 3021 [3–6].
- 516 Transcript of 'Erin', 22 August 2022, 3021 [6–10].
- 517 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 2, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Erin', 22 August 2022, 3021 [10–16].
- 518 Transcript of 'Erin', 22 August 2022, 3021 [18–24].
- 519 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 1, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Erin', 22 August 2022, 3029 [10–26].
- 520 Statement of 'Erin', 18 July 2022, Annexure [Erin]–001; Transcript of 'Erin', 22 August 2022, 3021 [18–31].
- 521 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 522 Transcript of 'Erin', 22 August 2022, 3021 [35–39].
- 523 Transcript of 'Erin', 22 August 2022, 3021 [39–44].
- 524 Transcript of 'Erin', 22 August 2022, 3021 [46]–3022 [1].
- 525 Transcript of 'Erin', 22 August 2022, 3022 [3–6].
- 526 Transcript of 'Erin', 22 August 2022, 3022 [6–16].
- 527 Transcript of 'Erin', 22 August 2022, 3022 [21–25].
- 528 Transcript of 'Erin', 22 August 2022, 3022 [25–31].
- 529 Statement of 'Erin', 18 July 2022, 4 [20].
- 530 Transcript of 'Erin', 22 August 2022, 3022 [33–38].
- 531 Transcript of 'Erin', 22 August 2022, 3023 [13–20].
- 532 Transcript of 'Erin', 22 August 2022, 3023 [20–24].
- 533 Transcript of 'Erin', 22 August 2022, 3023 [28–30].
- 534 Transcript of 'Erin', 22 August 2022, 3023 [32–41].
- 535 Transcript of 'Erin', 22 August 2022, 3023 [32]–3024 [6].
- 536 Transcript of 'Erin', 22 August 2022, 3024 [8–15].
- 537 Transcript of 'Erin', 22 August 2022, 3024 [16–18].
- 538 Transcript of 'Erin', 22 August 2022, 3024 [18–24].
- 539 Transcript of 'Erin', 22 August 2022, 3024 [31–34].
- 540 Transcript of 'Erin', 22 August 2022, 3024 [31–45].
- 541 Transcript of 'Erin', 22 August 2022, 3024 [47]–3025 [3].
- 542 Transcript of 'Erin', 22 August 2022, 3026 [29–41].
- 543 Transcript of 'Erin', 22 August 2022, 3025 [4–6].
- 544 Transcript of 'Erin', 22 August 2022, 3026 [41]–3027 [1].
- 545 Transcript of 'Erin', 22 August 2022, 3030 [10–16].
- 546 Transcript of 'Erin', 22 August 2022, 3030 [18–22].

- 547 Transcript of 'Erin', 22 August 2022, 3030 [21–30].
- 548 Transcript of 'Erin', 22 August 2022, 3030 [32–41].
- 549 Transcript of 'Erin', 22 August 2022, 3030 [45]–3031 [12].
- 550 Transcript of 'Erin', 22 August 2022, 3031 [14–26].
- 551 Transcript of 'Erin', 22 August 2022, 3031 [28–33].
- 552 Transcript of 'Erin', 22 August 2022, 3030 [33–35].
- 553 Transcript of 'Erin', 22 August 2022, 3031 [28–31].
- 554 The names 'Jane' and 'Ada' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of 'Jane', 19 August 2022, 2858 [6–13].
- 555 Statement of 'Jane', 2 June 2022, 1 [4]–2 [6].
- 556 Statement of 'Jane', 2 June 2022, 1 [4]; Transcript of 'Jane', 19 August 2022, 2858 [38–45].
- 557 Statement of 'Jane', 2 June 2022, 1 [5]; Transcript of 'Jane', 19 August 2022, 2859 [6–16].
- 558 Transcript of 'Jane', 19 August 2022, 2859 [28–31].
- 559 Statement of 'Jane', 2 June 2022, 2 [7].
- 560 Statement of 'Jane', 2 June 2022, 1 [5].
- 561 Statement of 'Jane', 2 June 2022, 1–2 [5].
- 562 Statement of 'Jane', 2 June 2022, 2 [7].
- 563 Transcript of 'Jane', 19 August 2022, 2860 [4–12]; Statement of 'Jane', 2 June 2022, 2 [7–8].
- 564 Statement of 'Jane', 2 June 2022, 2 [8].
- 565 Statement of 'Jane', 2 June 2022, 2 [9].
- 566 Statement of 'Jane', 2 June 2022, 2 [10].
- 567 Statement of 'Jane', 2 June 2022, 2 [10]; Transcript of 'Jane', 19 August 2022, 2861 [10–19].
- 568 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 10.
- 569 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 9.
- 570 Statement of 'Jane', 2 June 2022, 3 [11].
- 571 Statement of 'Jane', 2 June 2022, 3 [11], [15].
- 572 Statement of 'Jane', 2 June 2022, 3 [11].
- 573 Transcript of 'Jane', 19 August 2022, 2861 [36].
- 574 Statement of 'Jane', 2 June 2022, 3 [12]; Transcript of 'Jane', 19 August 2022, 2861 [36–45].
- 575 Transcript of 'Jane', 19 August 2022, 2862 [27–37].
- 576 Statement of 'Jane', 2 June 2022, 3 [13].
- 577 Transcript of 'Jane', 19 August 2022, 2863 [21–27].
- 578 Statement of 'Jane', 2 June 2022, 3 [14].
- 579 Transcript of 'Jane', 19 August 2022, 2864 [14–19].
- 580 Transcript of 'Jane', 19 August 2022, 2864 [25–38].
- 581 Statement of 'Jane', 2 June 2022, 4 [16–17]; Transcript of 'Jane', 19 August 2022, 2866 [15–17].
- 582 Statement of 'Jane', 2 June 2022, 4 [16].
- 583 Statement of 'Jane', 2 June 2022, 5 [26].
- 584 Statement of 'Jane', 2 June 2022, 5 [26]; Transcript of 'Jane', 19 August 2022, 2865 [32–35], [39–44].
- 585 Transcript of 'Jane', 19 August 2022, 2865 [31–39].
- 586 Statement of 'Jane', 2 June 2022, 5 [26]; Transcript of 'Jane', 19 August 2022, 2865 [42–45].
- 587 Transcript of 'Jane', 19 August 2022, 2866 [7–25].
- 588 Statement of 'Jane', 2 June 2022, 4 [20]; Transcript of 'Jane', 19 August 2022, 2866 [15–25].
- 589 Transcript of 'Jane', 19 August 2022, 2866 [11–13].
- 590 Statement of 'Jane', 2 June 2022, 4 [20].

- 591 Transcript of 'Jane', 19 August 2022, 2866 [7–8], [30–38].
- 592 Statement of 'Jane', 2 June 2022, 4 [21].
- 593 Transcript of 'Jane', 19 August 2022, 2864 [44–47].
- 594 Statement of 'Jane', 2 June 2022, 5 [23].
- 595 Transcript of 'Jane', 19 August 2022, 2865 [3–10].
- 596 Transcript of 'Jane', 19 August 2022, 2865 [10–15].
- 597 Transcript of 'Jane', 19 August 2022, 2867 [18–31].
- 598 Transcript of 'Jane', 19 August 2022, 2862 [19–23].
- 599 Statement of 'Jane', 2 June 2022, 3 [15].
- 600 Statement of 'Jane', 2 June 2022, 5 [26].
- 601 Statement of 'Jane', 2 June 2022, 7 [33].
- 602 Statement of 'Jane', 2 June 2022, 7 [33].
- 603 Transcript of 'Jane', 19 August 2022, 2866 [40–47].
- 604 The name 'Otis' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.  
Statement of 'Otis', 23 August 2022, 1 [4].
- 605 Statement of 'Otis', 23 August 2022, 1 [4].
- 606 Statement of 'Otis', 23 August 2022, 1 [5], 2 [7].
- 607 Statement of 'Otis', 23 August 2022, 1 [6].
- 608 Statement of 'Otis', 23 August 2022, 1 [5].
- 609 Statement of 'Otis', 23 August 2022, 1 [6]–2 [7].
- 610 Statement of 'Otis', 23 August 2022, 2 [7].
- 611 Statement of 'Otis', 23 August 2022, 2 [8].
- 612 Statement of 'Otis', 23 August 2022, 2 [10].
- 613 Statement of 'Otis', 23 August 2022, 2 [10].
- 614 Statement of 'Otis', 23 August 2022, 2 [10].
- 615 Statement of 'Otis', 23 August 2022, 2 [10].
- 616 Statement of 'Otis', 23 August 2022, 2 [11].
- 617 Statement of 'Otis', 23 August 2022, 2 [11].
- 618 Statement of 'Otis', 23 August 2022, 2 [11].
- 619 Statement of 'Otis', 23 August 2022, 2 [11].
- 620 Statement of 'Otis', 23 August 2022, 2 [12].
- 621 Statement of 'Otis', 23 August 2022, 3 [15]–4 [22].
- 622 Statement of 'Otis', 23 August 2022, 3 [15].
- 623 Statement of 'Otis', 23 August 2022, 2 [12].
- 624 Statement of 'Otis', 23 August 2022, 3 [16].
- 625 Statement of 'Otis', 23 August 2022, 3 [16].
- 626 Statement of 'Otis', 23 August 2022, 3 [17]–4 [19].
- 627 Statement of 'Otis', 23 August 2022, 4 [18–19].
- 628 Statement of 'Otis', 23 August 2022, 3 [17].
- 629 Statement of 'Otis', 23 August 2022, 4 [21].
- 630 Statement of 'Otis', 23 August 2022, 4 [19].
- 631 Statement of 'Otis', 23 August 2022, 4 [19].
- 632 Statement of 'Otis', 23 August 2022, 3 [17].
- 633 Statement of 'Otis', 23 August 2022, 3 [17], 4 [19], 4 [21].

- 634 Statement of 'Otis', 23 August 2022, 3 [17].
- 635 Statement of 'Otis', 23 August 2022, 4 [18].
- 636 Statement of 'Otis', 23 August 2022, 4–5 [24].
- 637 Statement of 'Otis', 23 August 2022, 3 [13].
- 638 Statement of 'Otis', 23 August 2022, 3 [15].
- 639 Statement of 'Otis', 23 August 2022, 3 [13].
- 640 Statement of 'Otis', 23 August 2022, 6 [32].
- 641 Statement of 'Otis', 23 August 2022, 6 [32].
- 642 Statement of 'Otis', 23 August 2022, 4–5 [24].
- 643 Statement of 'Otis', 23 August 2022, 4 [23].
- 644 Statement of 'Otis', 23 August 2022, 4 [23].
- 645 Statement of 'Otis', 23 August 2022, 4 [23].
- 646 Statement of 'Otis', 23 August 2022, 5 [25].
- 647 Statement of 'Otis', 23 August 2022, 5 [26].
- 648 Statement of 'Otis', 23 August 2022, 5 [26].
- 649 Statement of 'Otis', 23 August 2022, 5 [26].
- 650 Statement of 'Otis', 23 August 2022, 5 [27].
- 651 Statement of 'Otis', 23 August 2022, 5 [27].
- 652 Statement of 'Otis', 23 August 2022, 5 [27].
- 653 Statement of 'Otis', 23 August 2022, 5 [27].
- 654 Statement of 'Otis', 23 August 2022, 6 [31].
- 655 Statement of 'Otis', 23 August 2022, 5 [28].
- 656 Statement of 'Otis', 23 August 2022, 5 [28].
- 657 Statement of 'Otis', 23 August 2022, 6 [33].
- 658 Statement of 'Otis', 23 August 2022, 6 [33].
- 659 Statement of 'Otis', 23 August 2022, 5 [29].
- 660 Statement of 'Otis', 23 August 2022, 5 [29]–6 [30].
- 661 Statement of 'Otis', 23 August 2022, 6 [30].
- 662 Transcript of Brett Robinson, 17 June 2022, 1536 [8–37].
- 663 Statement of Brett Robinson, 2 June 2022, 1 [6]–2 [7], 3 [14].
- 664 Transcript of Brett Robinson, 17 June 2022, 1541 [18–33].
- 665 Transcript of Brett Robinson, 17 June 2022, 1543 [8–14]; Statement of Brett Robinson, 2 June 2022, 3 [17].
- 666 Transcript of Brett Robinson, 17 June 2022, 1541 [44]–1542 [25].
- 667 Statement of Brett Robinson, 2 June 2022, 4 [19–20]; Transcript of Brett Robinson, 17 June 2022, 1542 [34]–1543 [1].
- 668 Statement of Brett Robinson, 2 June 2022, 3 [18].
- 669 Transcript of Brett Robinson, 17 June 2022, 1543 [18–21].
- 670 Transcript of Brett Robinson, 17 June 2022, 1543 [23]–1544 [8].
- 671 Transcript of Brett Robinson, 17 June 2022, 1544 [25–39].
- 672 Statement of Brett Robinson, 2 June 2022, 6 [31–34].
- 673 Statement of Brett Robinson, 2 June 2022, 6 [36].
- 674 Statement of Brett Robinson, 2 June 2022, 7 [37].
- 675 Statement of Brett Robinson, 2 June 2022, 7 [37].
- 676 Transcript of Brett Robinson, 17 June 2022, 1545 [24–5].
- 677 Statement of Brett Robinson, 2 June 2022, 7 [38–39].
- 678 Statement of Brett Robinson, 2 June 2022, 7 [40].



- 679 Statement of ‘Simon’, 7 July 2022, 1 [4].
- 680 Statement of ‘Fred’, 24 August 2022, 1 [6]; Statement of ‘Jane’, 2 June 2022, 2 [7]; Transcript of ‘Erin’, 22 August 2022, 3019 [1–5]; Statement of Brett Robinson, 2 June 2022, 1 [4].
- 681 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, ‘Ben’, undated) 2; Statement of ‘Simon’, 7 July 2022, 1 [5]; Transcript of ‘Erin’, 22 August 2022, 3020 [43–46].
- 682 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, ‘Ben’, undated) 1; Anonymous session, 16 February 2022.
- 683 Submission of Sebastian Buscemi, 28 August 2021, 5; Department of Communities, ‘Issues Briefing to the Minister: Update on AYDC Matters Referred by Cassy O’Connor’s Office’, December 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 684 Tasmania Police, Unsigned ‘Statement of Ashley Youth Detention Centre staff member’, November 2020, 3 [28–33].
- 685 Anonymous session, 16 February 2022.
- 686 Anonymous session, 16 February 2022.
- 687 Transcript of ‘Fred’, 25 August 2022, 3342 [17–21].
- 688 Statement of ‘Eve’, 18 August 2022, 4 [22]–[23].
- 689 Submission 086 Angela Sdrinis Legal, 70.
- 690 Transcript of ‘Erin’, 22 August 2022, 3028 [21–45], 3028 [47]–3029 [1].
- 691 Statement of ‘Charlotte’, 31 January 2022, 1.
- 692 Statement of ‘Erin’, 18 July 2022, 6 [33–34].
- 693 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, ‘Ben’, undated) 3; Statement of ‘Otis’, 23 August 2022, 3 [15].
- 694 Statement of ‘Otis’, 23 August 2022, 3 [17], 4 [19], [21].
- 695 Statement of ‘Otis’, 23 August 2022, 5 [26]; Statement of ‘Warren’, 19 May 2022, 4 [20].
- 696 Transcript of ‘Simon’, 18 August 2022, 2758 [7–10]; Statement of ‘Erin’, 18 July 2022, 7 [37].
- 697 Transcript of ‘Simon’, 18 August 2022, 2758 [7–22]; Statement of ‘Erin’, 18 July 2022, 7 [37–38].
- 698 Statement of Angela Sdrinis, 5 May 2022, 57.
- 699 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 13.
- 700 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 13.
- 701 The name ‘Alysha’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Alysha’, 16 August 2022, 55 [278].
- 702 Statement of ‘Alysha’, 16 August 2022, 16 [74].
- 703 Statement of ‘Alysha’, 16 August 2022, 26 [124].
- 704 *Youth Justice Act 1997* s 132(d)–(f).
- 705 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 37(c).
- 706 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, ‘Ben’, undated) 4.
- 707 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 10; Transcript of Michael Pervan, 26 August 2022, 3501 [40–44].
- 708 Transcript of Michael Pervan, 26 August 2022, 3518 [6–13].
- 709 Transcript of Jacqueline Allen, 25 August 2022, 3378 [19–37], 3379 [19–33].
- 710 Transcript of Jacqueline Allen, 25 August 2022, 3378 [19–37]; 3380 [46]–3381 [5].
- 711 Transcript of Jacqueline Allen, 25 August 2022, 3379 [28]–3380 [42].
- 712 Statement of Mandy Clarke, 19 August 2022, 9 [29].
- 713 Statement of Mandy Clarke, 19 August 2022, 5 [6].

- 714 Transcript of Pamela Honan, 19 August 2022, 2945 [29–42].
- 715 Transcript of Pamela Honan, 19 August 2022, 2945 [44–47].
- 716 Transcript of Michael Pervan, 26 August 2022, 3533 [5–10].
- 717 Transcript of Michael Pervan, 26 August 2022, 3533 [5–15].
- 718 Transcript of Stuart Watson, 23 August 2022, 3159 [6–14].
- 719 Transcript of Stuart Watson, 23 August 2022, 3159 [16]–3160 [6].
- 720 Statement of ‘Erin’, 18 July 2022, 3 [18].
- 721 The names ‘Ira’, ‘Lester’ and ‘Stan’ are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 722 Children and Youth Services, ‘Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns’, 6 May 2016, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 723 Statement of Mandy Clarke, 19 August 2022, 3 [2].
- 724 Transcript of Mandy Clarke, 25 August 2022, 3400 [31–37].
- 725 Refer to, for example, Statement of ‘Erin’, 18 July 2022, 3 [18]; Statement of ‘Max’, 19 May 2022, 8 [33].
- 726 Anonymous session, 15 February 2022.
- 727 Statement of ‘Ben’, 29 March 2022, 5 [20–21].
- 728 Statement of ‘Ben’, 29 March 2022, 5 [21].
- 729 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 730 Transcript of ‘Erin’, 22 August 2022, 3026 [29–41].
- 731 Statement of ‘Otis’, 23 August 2022, 2 [12].
- 732 Statement of ‘Fred’, 24 August 2022, 2 [12]; Transcript of ‘Fred’, 25 August 2022, 3343 [28–37].
- 733 Statement of ‘Max’, 19 May 2022, 6 [26], 10 [42].
- 734 Statement of ‘Otis’, 23 August 2022, 5 [26].
- 735 Statement of ‘Warren’, 19 May 2022, Attachment [Warren]–001 (Additional statement, ‘Warren’, 24 November 2021) 2.
- 736 Submission 086 Angela Sdrinis Legal, 60.
- 737 Submission 086 Angela Sdrinis Legal, 60.
- 738 Statement of ‘Alysha’, 16 August 2022, 86 [436].
- 739 Transcript of ‘Max’, 23 August 2022, 3123 [24–43].
- 740 Statement of ‘Ben’, 29 March 2022, 7 [30].
- 741 Statement of ‘Ben’, 29 March 2022, 4 [19].
- 742 Transcript of Michael Guerzoni, 4 May 2022, 203 [26–30].
- 743 Transcript of Michael Guerzoni, 4 May 2022, 203 [21–25].
- 744 Statement of Michael Guerzoni, 29 April 2022, 24–25 [83].
- 745 Statement of Michael Guerzoni, 29 April 2022, 20–21 [68].
- 746 Transcript of Donald Palmer, 4 May 2022, 202 [45]–203 [3].
- 747 Statement of Samantha Cromptvoets, 10 September 2022, 10 [38].
- 748 Transcript of Sarah Spencer, 18 August 2022, 2820 [28–37], [42–46].
- 749 Sarah Spencer, *Procedural Fairness Response*, 14 July 2023.
- 750 Statement of Fiona Atkins, 15 August 2022, 15 [48].
- 751 Transcript of Fiona Atkins, 24 August 2022, 3286 [36–45].
- 752 Transcript of Stuart Watson, 23 August 2022, 3157 [7–13].
- 753 Transcript of Stuart Watson, 23 August 2022, 3157 [16–19].
- 754 Transcript of Stuart Watson, 23 August 2022, 3161 [5–9].

- 755 Statement of ‘Max’, 19 May 2022, 6 [27]; Statement of ‘Warren’, 19 May 2022, 3 [16].
- 756 Statement of ‘Otis’, 23 August 2022, 4 [23].
- 757 Transcript of Leanne McLean and Richard Connock, 24 August 2022, 3310 [16–34].
- 758 Statement of Mark Morrissey, 9 August 2022, 4 [23].
- 759 Statement of ‘Ben’, 29 March 2022, 4 [18]; Statement of Brett Robinson, 2 June 2022, 4 [23].
- 760 Statement of Peter Graham, 16 August 2022, Attachment D (‘Continuation of Positive Registration: Reasons for Decision – [Stan]’, 7 July 2022) 5.
- 761 Statement of Pamela Honan, 18 August 2022, 21 [26.1].
- 762 Transcript of Pamela Honan, 19 August 2022, 2941 [12–17].
- 763 Transcript of Pamela Honan, 19 August 2022, 2941 [31–33].
- 764 Statement of Pamela Honan, 18 August 2022, 21 [26.2–26.3].
- 765 Transcript of Mandy Clarke, 25 August 2022, 3400 [39]–3401 [4].
- 766 Transcript of Michael Pervan, 25 August 2022, 3456 [44]–3457 [10].
- 767 Transcript of Michael Pervan, 25 August 2022, 3457 [17–22].
- 768 Transcript of Michael Pervan, 26 August 2022, 3489 [21–31], 3489 [37]–3490 [8].

## Case study 2: Harmful sexual behaviours

- 769 The names ‘Max’, ‘Henry’ and ‘Ray’ are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 770 The name ‘Ben’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Ben’, 29 March 2022, 6 [27]–7 [28].
- 771 Statement of ‘Ben’, 29 March 2022, 6 [27]–7 [28].
- 772 Statement of ‘Ben’, 29 March 2022, 7 [30]; Statement of ‘Ben’, 29 March 2022, Annexure [Ben]-001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 3–4.
- 773 Statement of ‘Ben’, 29 March 2022, Annexure [Ben]-001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 2.
- 774 Statement of ‘Ben’, 29 March 2022, 6.
- 775 The name ‘Charlotte’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Charlotte’, 31 January 2022, 2.
- 776 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [22–30].
- 777 Statement of ‘Charlotte’, 31 January 2022, 3; Transcript of ‘Charlotte’, 24 August 2022, 3206 [18–27].
- 778 The name ‘Fred’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Fred’, 24 August 2022, 3 [14], [16].
- 779 Statement of ‘Fred’, 24 August 2022, 5 [28].
- 780 The name ‘Oscar’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of ‘Oscar’, 29 July 2022, 1 [3]. In relation to this individual, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged.
- 781 Statement of ‘Oscar’, 29 July 2022, 2 [6].
- 782 Statement of ‘Oscar’, 29 July 2022, 2 [7], [11].
- 783 The name ‘Erin’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of ‘Erin’, 22 August 2022, 3019 [34–36].
- 784 Transcript of ‘Erin’, 22 August 2022, 3022 [25–29].
- 785 Transcript of ‘Erin’, 22 August 2022, 3023 [13–30].
- 786 Transcript of ‘Erin’, 22 August 2022, 3023 [45]–3024 [18].
- 787 Transcript of ‘Erin’, 22 August 2022, 3024 [4]–3025 [6].

- 788 Statement of ‘Max’, 19 May 2022, 1 [3], 3 [16]; Transcript of ‘Max’, 23 August 2022, 3109 [43–45].
- 789 Statement of ‘Max’, 19 May 2022, 1 [3], 3 [16], 4 [17]; Transcript of ‘Max’, 23 August 2022, 3111 [15]–3112 [8], 3113 [39–40].
- 790 Statement of ‘Max’, 19 May 2022, 4 [20].
- 791 Statement of ‘Max’, 19 May 2022.
- 792 Statement of ‘Ben’, 29 March 2022, Annexure [Ben]-001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 2–3; Statement of ‘Max’, 19 May 2022, 3 [16]; Serious Events Review Team, ‘Serious Event Review Report – Review of the matter of [Henry]’, 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 793 Transcript of ‘Erin’, 22 August 2022, 3022 [25–31]; Ashley Youth Detention Centre, ‘Incident Report’, 5 June 2019, 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [22–30]; Statement of ‘Charlotte’, 31 January 2022, 2.
- 794 Statement of ‘Ben’, 29 March 2022, Annexure [Ben]-001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 2; Transcript of ‘Erin’, 22 August 2022, 3023 [20–24], 3025 [4–6], 3026 [29–41].
- 795 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]-001 (Handwritten Submission to the National Royal Commission, ‘Ben’, undated) 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [35–45], 3203 [35–39].
- 796 The names ‘Albert’ and ‘Finn’ are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 797 *Youth Justice Act 1997* s 132.
- 798 *Youth Justice Act 1997* s 129(1)(a).
- 799 Refer to, for example, Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 3 [1.3.3], 40 [8.6], 44 [8.10].
- 800 After 31 May 2022, the placement and transfer of children and young people in units at Ashley Youth Detention Centre was to be conducted in accordance with the *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* (31 May 2022). The decision-making process and considerations are substantively similar to those previously in place and listed above, with unit allocations and transfer requests now considered by the Risk Assessment Process Team and Weekly Review Meeting respectively, with both reviewed by the Centre Manager.
- 801 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of Fiona Atkins, 15 August 2022, 11 [39(a)]; Statement of Patrick Ryan, 18 August 2022, 13 [128]; Statement of ‘Piers’, 16 August 2022, 15 [45(b)]; the name ‘Piers’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023; Statement of ‘Digby’, 8 August 2022, 16 [56(b)]; the name ‘Digby’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [31].
- 802 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Secretary Webster to the Ombudsman including appendices, 14 November 2018); Statement of Patrick Ryan, 18 August 2022, 13 [129]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [30], [32]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of ‘Digby’, 8 August 2022, 16 [56(a)]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Fiona Atkins, 15 August 2022, 11 [39(c)]; Statement of ‘Piers’, 15 August 2022, 16 [45(c)].
- 803 Statement of ‘Digby’, 8 August 2022, 16 [56].
- 804 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Secretary Webster to the Ombudsman including appendices, 14 November 2018) 157–160.
- 805 Statement of ‘Alysha’, 16 August 2022, 27 [130]; the name ‘Alysha’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 806 Statement of Stuart Watson, 16 August 2022, 8 [49a]; Transcript of Stuart Watson, 23 August 2022, 3179 [16–21].
- 807 Statement of Stuart Watson, 16 August 2022, 8 [49a].
- 808 Statement of Stuart Watson, 16 August 2022, 8 [49a].
- 809 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].

- 810 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].
- 811 Statement of 'Alysha', 16 August 2022, 51 [262].
- 812 Statement of 'Alysha', 16 August 2022, 47 [241].
- 813 Statement of 'Alysha', 16 August 2022, 27 [130].
- 814 Statement of 'Alysha', 16 August 2022, 27 [130].
- 815 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 816 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 817 Stuart Watson, 'Response to the Findings of a Serious Event Review Team (SERT) Review in Relation to Former AYDC Resident [Henry]', 31 May 2021, 3-4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 818 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [30], [31]; Statement of 'Digby', 8 August 2022, 17 [57]; Statement of 'Piers', 15 August 2022, 17 [47]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [60].
- 819 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 16, produced by the Tasmanian Government in response to a Commission notice to produce; Email from 'Piers' to 'Alysha', 22 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 820 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 16, produced by the Tasmanian Government in response to a Commission notice to produce.
- 821 Ashley Youth Detention Centre, 'Standard Operating Procedure #8: Supervision and Movement of Young People', 2015, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 822 Ashley Youth Detention Centre, 'Standard Operating Procedure #8: Supervision and Movement of Young People', 2015, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 823 Refer to, for example, Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map', 19 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 824 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24, produced by the Tasmanian Government in response to a Commission notice to produce.
- 825 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24–25, produced by the Tasmanian Government in response to a Commission notice to produce.
- 826 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24–25, 32, produced by the Tasmanian Government in response to a Commission notice to produce.
- 827 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.
- 828 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.
- 829 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 830 Statement of Michael Pervan, 27 July 2022, 59 [161].
- 831 Statement of Pamela Honan, 18 August 2022, 34 [56].
- 832 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 833 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 4, produced by the Tasmanian Government in response to a Commission notice to produce.



- 834 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 835 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 836 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 837 *Youth Justice Act 1997* s 140(3).
- 838 Statement of Michael Pervan, 27 July 2022, Annexure 2 ('Instrument of Delegation', Department of Communities, 9 March 2022).
- 839 *Youth Justice Act 1997* s 140(3).
- 840 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 841 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 842 *Youth Justice Act 1997* s 140(2)(b)(i); Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 843 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 844 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 845 Statement of Michael Pervan, 6 June 2022, 52 [232]; Transcript of Michael Pervan, 17 June 2022, 1624 [43]–1625 [13]; Transcript of Claire Lovell, 4 July 2022, 2296 [17–20].
- 846 Michael Pervan, *Procedural Fairness Response*, 21 July 2023, 2 [7]–3 [9]; Department for Education, Children and Young People, *Child Safety Services Careers* (Web Page) <<https://www.decyp.tas.gov.au/about-us/employment/child-safety-services-careers/>>.
- 847 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 848 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 849 Children and Youth Services, 'Information Sheet: Serious Event Reviews', 29 August 2019, 1, produced by the Department for Education, Children and Young People in response to a Commission notice to produce.
- 850 Statement of Ginna Webster, 13 January 2023, 48 [80.1].
- 851 Statement of former Manager, Serious Events Review Team, 11 November 2022, 13 [59].
- 852 Transcript of Michael Pervan, 26 August 2022, 3527 [15–21].
- 853 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [76]. Refer also to Children and Youth Services, 'Information Sheet: Serious Event Reviews', 29 August 2019, which states that referrals to the Serious Event Review Team were made by the Secretary or Deputy Secretary.
- 854 Statement of former Manager, Serious Events Review Team, 11 November 2022, 4 [17], 16 [77].
- 855 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [78–82].
- 856 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].
- 857 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].
- 858 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].
- 859 Statement of former Manager, Serious Events Review Team, 11 November 2022, 4 [17], 15 [72], 16 [84].
- 860 Statement of former Manager, Serious Events Review Team, 11 November 2022, Annexure 10 (Flow chart: 'Serious Events Review – Governance', undated).
- 861 Statement of former Manager, Serious Events Review Team, 11 November 2022, 10 [45].

- 862 Children and Youth Services, 'Information Sheet: Serious Event Review', 29 August 2019, 2, produced by the Department for Education, Children and Young People in response to a Commission notice to produce.
- 863 Refer to, for example, Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 17 February 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 25 February 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 31 January 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Albert]', 10 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 11 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 23 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 864 The only incident that was not recorded as a detention offence may be found at Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 24 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 865 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 866 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 867 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 868 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 869 Psychologist, Ashley Youth Detention Centre, 'Violence Risk Assessment', 5 April 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 870 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 871 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Finn]', 10 June 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 872 Statement of 'Max', 19 May 2022, 1 [3].
- 873 Statement of 'Alysha', 16 August 2022, 25 [121]; Statement of 'Max', 19 May 2022, 3 [14], 11 [48].
- 874 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].
- 875 Statement of 'Alysha', 16 August 2022, 25 [121].
- 876 Statement of 'Max', 19 May 2022, 3 [14].
- 877 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 878 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Henry]', 14 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Henry]', 12 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 879 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 880 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 881 Transcript of Veronica Burton, 22 August 2022, 3093 [30–33].
- 882 Ashley Youth Detention Centre, 'Client Request in relation to [Henry]', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.



- 883 The name 'Ray' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Custodial Youth Justice, 'File Cover Sheet', September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 884 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Alysha', 22 August 2022, 3057 [21–25].
- 885 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 886 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 887 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 888 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, 3–5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 889 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 890 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 891 Email from 'Alysha' to Pamela Honan, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]', 18 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 892 Statement of 'Alysha', 16 August 2022, 23 [108]; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 6 January 2020, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 893 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 894 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, 21 [208].
- 895 The names 'Floyd' and 'Ned' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [5–6].
- 896 Statement of 'Max', 19 May 2022, 2 [5–6].
- 897 Statement of 'Max', 19 May 2022, 2 [7].
- 898 Statement of 'Max', 19 May 2022, 2 [10]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].
- 899 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].
- 900 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].
- 901 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3112 [10–25].
- 902 Statement of 'Max', 19 May 2022, 3 [16].
- 903 The name 'Arlo' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 904 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–12, produced by the Tasmanian Government in response to a Commission notice to produce.

- 905 Statement of 'Max', 19 May 2022, 4 [17].
- 906 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 907 Statement of 'Max', 19 May 2022, 4 [17–18].
- 908 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 909 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 910 Statement of 'Max', 19 May 2022, 4 [20].
- 911 Statement of 'Max', 19 May 2022, 4 [21]–5 [22].
- 912 Statement of 'Max', 19 May 2022, 5 [22].
- 913 Ashley Youth Detention Centre, 'Care Plan and Multi-Disciplinary Team Minutes [Max]', 23 August 2018, 2–3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Care Plan and Multi-Disciplinary Team Minutes [Max]', 20 September 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 914 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 3, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 915 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 916 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 917 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 918 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 919 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 920 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 921 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 922 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 923 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 924 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10–11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 925 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of 'Max', 19 May 2022, 4 [17].
- 926 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10–11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 927 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 928 Serious Events Review Team, Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 929 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 930 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

- 931 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 932 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 933 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 934 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 935 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 16, produced by the Tasmanian Government in response to a Commission notice to produce.
- 936 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 937 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 938 Stuart Watson, 'Response to the Findings of a Serious Event Review Team Review in Relation to AYDC Resident [Henry]', 31 May 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 939 Statement of Pamela Honan, 18 August 2022, 38 [60.1].
- 940 Department of Communities, 'CCTV Recording of 7 August 2019', 7 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 941 The name 'Jonathan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 942 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 943 The name 'Frank' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 944 The name 'Maude' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 945 Ashley Youth Detention Centre, 'Client Request', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 946 Ashley Youth Detention Centre, 'Client Request', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 947 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 948 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 949 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 950 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 951 Ashley Youth Detention Centre, 'Incident Report Form in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 952 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce. Note that the incident report records the date of the incident as 7 September 2019, which we presume to be a typographical error on the basis that the report indicates the CCTV footage was viewed and the report was signed on 9 August 2019, and on the basis that the incident date of 7 August 2019 is confirmed in other documentary and witness evidence.

- 953 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 954 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 955 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 956 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 957 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 958 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 959 The name 'Clive' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 960 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 961 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 962 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 963 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 964 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 965 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 966 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 967 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 968 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 969 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 970 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 971 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 972 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 973 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 974 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 975 Transcript of Madeleine Gardiner, 22 August 2022, 3010 [20–24].
- 976 Statement of Madeleine Gardiner, 15 August 2022, 27–28 [50].
- 977 Transcript of Madeleine Gardiner, 22 August 2022, 3010 [7–10].
- 978 Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5], [26–29].

- 979 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 980 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 981 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5].
- 982 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 3–4 produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5].
- 983 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 984 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 985 Statement of Madeleine Gardiner, 15 August 2022, 27–28 [50]; Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 986 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 987 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 988 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 989 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 990 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 991 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 992 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33–34 [144], 35 [150]; Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 14, produced by the Tasmanian Government in response to a Commission notice to produce.
- 993 Letter from Mandy Clarke to Leanne McLean, 19 May 2020.
- 994 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 36 [152], 37–38 [162]; Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 995 Letter from Mandy Clarke to Leanne McLean, 19 May 2020.
- 996 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 997 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 998 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 999 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1000 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1001 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.



- 1002 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1003 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1004 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1005 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1006 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1007 Patrick Ryan, *Procedural Fairness Response*, 12 July 2023, 2 [6].
- 1008 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1009 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3–6, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from 'Piers' to 'Maude' et al, 21 November 2019); Transcript of Veronica Burton, 22 August 2022, 3101 [17–22]; Statement of Fiona Atkins, 15 August 2022, 21–22 [96(e)]; Transcript of Pamela Honan, 19 August 2022, 2952 [30–42], 2953 [26–37]; Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 37 [161].
- 1010 Statement of 'Alysha', 16 August 2022, 38–40 [198].
- 1011 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1012 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 1.
- 1013 Refer also to email from Operations Manager to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1014 Email from Madeleine Gardiner to Patrick Ryan and Operations Manager, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1015 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].
- 1016 Email from Operations Manager to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1017 Email from Operations Manager to Madeleine Gardiner, 21 August 2019.
- 1018 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].
- 1019 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].
- 1020 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).
- 1021 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).
- 1022 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).
- 1023 Email from Madeleine Gardiner to Patrick Ryan, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1024 Email from Patrick Ryan to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1025 Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1026 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1027 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1028 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1029 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1030 Email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1031 Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, 4 [27].
- 1032 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 10 [49]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 1 [6].
- 1033 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 1–2, 8–9, produced by the Tasmanian Government in response to a Commission notice to produce; email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1034 Email from former Operations Coordinator to former Director, Strategic Youth Services, Department of Communities, 1 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1035 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1036 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1037 Tasmania Police, 'Table of Allegations and Incidents of Child Sexual Abuse', 20 July 2021, produced by Tasmania Police in response to a Commission notice to produce.
- 1038 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Psychologist, Ashley Youth Detention Centre, 'Incident Log', 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1039 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Psychologist, Ashley Youth Detention Centre, 'Incident Log', 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1040 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1041 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1042 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1043 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1044 Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1045 Email from Patrick Ryan to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1046 Email from Patrick Ryan to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1047 Statement of Madeleine Gardiner, 15 August 2022, 49 [92(c)].
- 1048 Statement of Madeleine Gardiner, 15 August 2022, 28 [50], 49 [92(b)]; Email from Madeleine Gardiner to former Director, Strategic Youth Services, Department of Communities, 5 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1049 Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, 2 [14]; Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, Annexure 1 ('Ashley Youth Detention Centre Program Summary Table 2018–19', undated).



- 1050 Statement of Patrick Ryan, 18 August 2022, 3 [22]–4 [32].
- 1051 Statement of Patrick Ryan, 18 August 2022, 4 [32].
- 1052 Statement of Patrick Ryan, 18 August 2022, 20 [195–199].
- 1053 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 10 [50]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 1 [7].
- 1054 Statement of Pamela Honan, 18 August 2022, 13 [12.5–12.6].
- 1055 Serious Events Review Team, ‘Serious Event Review Report – Review of the matter of [Henry]’, 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1056 Statement of Madeleine Gardiner, 15 August 2022, 46 [89(a)]; Statement of Madeleine Gardiner, 15 August 2022, Annexure MG-26 (Email from Ashley Professional Services to Madeleine Gardiner and Patrick Ryan, 23 August 2019).
- 1057 Statement of Madeleine Gardiner, 15 August 2022, 46 [89(a)]; Statement of Madeleine Gardiner, 15 August 2022, Annexure MG-26 (Email from Ashley Professional Services to Madeleine Gardiner and Patrick Ryan, 23 August 2019).
- 1058 Department of Communities, ‘CARDI Conversation Summary Report in relation to [Henry]’, 25 March 2022, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1059 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 36 [152].
- 1060 Department of Communities, ‘CARDI Conversation Summary Report in relation to [Henry]’, 25 March 2022, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1061 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1062 Statement of Patrick Ryan, 18 August 2022, 19 [183].
- 1063 Statement of Patrick Ryan, 18 August 2022, 19 [181].
- 1064 Statement of Patrick Ryan, 7 September 2022, 1 [1].
- 1065 Statement of Patrick Ryan, 7 September 2022, 1 [2].
- 1066 Statement of Greg Brown, 28 November 2022, 32 [93].
- 1067 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 12 [63]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 2 [10].
- 1068 Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 2 [11].
- 1069 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1070 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1071 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, 2 produced by the Tasmanian Government in response to a Commission notice to produce.
- 1072 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1073 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1074 Department of Communities, ‘Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre’, 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1075 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1076 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1077 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1078 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1079 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1080 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1081 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1082 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1083 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1084 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1085 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1086 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1087 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1088 Transcript of Patrick Ryan, 7 September 2022, 3636 [46–47], 3637 [15–19].
- 1089 Transcript of Patrick Ryan, 7 September 2022, 3634 [43–46].
- 1090 Transcript of Patrick Ryan, 7 September 2022, 3635 [34–35].
- 1091 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019).
- 1092 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 1–2.
- 1093 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 3.

- 1094 Statement of Patrick Ryan, 18 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 2.
- 1095 Statement of Greg Brown, 28 November 2022, 32 [93–94].
- 1096 Statement of Pamela Honan, 18 August 2022, 35 [59.1].
- 1097 Statement of Pamela Honan, 18 August 2022, 35 [59.1].
- 1098 Statement of Pamela Honan, 18 August 2022, 35 [59.1].
- 1099 Statement of Pamela Honan, 18 August 2022, 35 [59.1].
- 1100 Statement of Pamela Honan, 18 August 2022, 24 [31.2].
- 1101 Statement of Mandy Clarke, 19 August 2022, 17 [69.1]–18 [69.2].
- 1102 Statement of Michael Pervan, 23 August 2022, 56 [229(i)].
- 1103 Statement of Michael Pervan, 23 August 2022, 56 [229(i)].
- 1104 Transcript of Michael Pervan, 26 August 2022, 3525 [22–36].
- 1105 Statement of Pamela Honan, 18 August 2022, 23 [30.2]; Transcript of Pamela Honan, 19 August 2022, 2949 [9–13].
- 1106 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 18 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1107 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 20 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1108 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 20 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1109 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Transcript of Chris Gunson SC, Counsel for the State of Tasmania, 19 August 2022, 2983 [28]–2984 [42].
- 1110 Transcript of Patrick Ryan, 7 September 2022, 3628 [14–17].
- 1111 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]', 19 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1112 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 26 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Authorisation for Use of Isolation in relation to [Ray]', 26 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1113 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 28 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 1 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 3 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 5 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 8 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 24 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 27 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1114 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 28 September 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 1 October 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, 3, produced by the Tasmanian Government in response to a Commission notice

- to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 3 October 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 5 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 8 November 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 24 November 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 27 November 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1115 Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 17 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1116 Refer to, for example, Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 2 October 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1117 Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1118 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1119 Email from Ashley Professional Services to 'Chester', 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce. 'Chester' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 1120 Email from 'Chester' to Ashley Professional Services, 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1121 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1122 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1123 Statement of Patrick Ryan, 18 August 2022, 21 [208].
- 1124 Statement of Patrick Ryan, 18 August 2022, 21 [206].
- 1125 Statement of Patrick Ryan, 18 August 2022, 21 [207–210]; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Compiled emails and other documents relating to planning and meetings in relation to 'Albert' and 'Finn').
- 1126 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Albert] and [Finn]', 14 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1127 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1128 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1129 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1130 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1131 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1132 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1133 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1134 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1135 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1136 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1137 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1138 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1139 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1140 Statement of Patrick Ryan, 18 August 2022, 22 [215]; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to ‘Digby’, 6 December 2019).
- 1141 Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to ‘Piers’, 22 November 2019).
- 1142 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].
- 1143 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].
- 1144 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].
- 1145 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33 [144].
- 1146 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33 [144].
- 1147 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 39 [169].
- 1148 Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 18 [99].
- 1149 Statement of Greg Brown, 28 November 2022, 32 [93–94], 33 [95–96]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, 13 [66].
- 1150 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 16 [76].
- 1151 Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to ‘Piers’, 22 November 2019).
- 1152 Transcript of Barry Nicholson, 19 August 2022, 2929 [26–34].
- 1153 Transcript of Barry Nicholson, 19 August 2022, 2930 [2–12].
- 1154 Statement of ‘Alysha’, 16 August 2022, 27 [132].
- 1155 Statement of ‘Alysha’, 16 August 2022, 27 [134].



- 1156 Statement of 'Alysha', 16 August 2022, 33 [167].
- 1157 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1158 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1159 Statement of 'Alysha', 16 August 2022, 28 [135].
- 1160 Statement of 'Alysha', 16 August 2022, 28 [136].
- 1161 Statement of 'Alysha', 16 August 2022, 28 [137], 29 [142–143].
- 1162 Statement of 'Alysha', 16 August 2022, 29–30 [144].
- 1163 Statement of 'Alysha', 16 August 2022, 31 [154–155].
- 1164 Statement of 'Alysha', 16 August 2022, 30 [147].
- 1165 Statement of 'Alysha', 16 August 2022, 30 [147].
- 1166 Statement of 'Alysha', 16 August 2022, 30 [148].
- 1167 Statement of 'Digby', 8 August 2022, 24.
- 1168 Statement of 'Piers', 15 August 2022, 30 [103(d)].
- 1169 Statement of 'Piers', 15 August 2022, 30 [103(d)].
- 1170 Statement of Patrick Ryan, 18 August 2022, 24 [225–226], [228].
- 1171 Statement of Patrick Ryan, 18 August 2022, 24 [228].
- 1172 Statement of Patrick Ryan, 7 September 2022, 24 [227].
- 1173 Statement of Patrick Ryan, 7 September 2022, 24 [228].
- 1174 Statement of 'Alysha', 16 August 2022, 30 [149].
- 1175 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1176 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 6 December 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1177 Statement of Pamela Honan, 18 August 2022, 1 [1.1].
- 1178 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1179 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1180 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1181 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, 12 [121].
- 1182 Statement of 'Alysha', 16 August 2022, 30 [150–151], [154–156].
- 1183 Statement of 'Alysha', 16 August 2022, 30 [151]; Email from Executive Officer to 'Alysha', 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Pamela Honan, 18 August 2022, 23 [30.1].
- 1184 Email from Executive Officer to 'Alysha', 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1185 Email from 'Alysha' to Executive Officer, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to Produce.
- 1186 Email from Executive Officer to 'Alysha', 6 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1187 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 6 December 2019; Letter from Leanne McLean to Michael Pervan, 10 December 2019, 1; Commissioner for Children and Young People, 'File Note', 6 December 2019.

- 1188 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 6 December 2019; Letter from Leanne McLean to Michael Pervan, 10 December 2019, 1.
- 1189 Commissioner for Children and Young People, 'File Note', 6 December 2019.
- 1190 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 1.
- 1191 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 1.
- 1192 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.
- 1193 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.
- 1194 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2; Transcript of Leanne McLean, 24 August 2022, 3316 [34–43].
- 1195 Statement of 'Alysha', 16 August 2022, 31 [157].
- 1196 Statement of 'Alysha', 16 August 2022, 31–32 [157].
- 1197 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.
- 1198 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.
- 1199 Letter from Leanne McLean to Michael Pervan, 10 December 2019.
- 1200 Letter from Leanne McLean to Michael Pervan, 10 December 2019, 2.
- 1201 Letter from Leanne McLean to Michael Pervan, 10 December 2019, 2.
- 1202 Transcript of Richard Connock, 24 August 2022, 3318 [10–32].
- 1203 James Cumming Investigation Services, 'Review into the Immediate and Post Management of a 13 December 2019 Incident at Ashley Youth Detention Centre', 26 March 2021, 112, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1204 Statement of Pamela Honan, 18 August 2022, 23 [30.2]; Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1205 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1206 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1207 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1208 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1209 Patrick Ryan, *Procedural Fairness Response*, 12 July 2023, 3 [13–14]
- 1210 Transcript of 'Alysha', 22 August 2022, 3050 [26]–3051 [2]; Transcript of Veronica Burton, 22 August 2022, 3095 [43]–3096 [30]; Statement of 'Alysha', 16 August 2022, 35 [178–179].
- 1211 Transcript of Veronica Burton, 22 August 2022, 3096 [32]–3097 [1].
- 1212 Statement of Veronica Burton, 4 August 2022, 4 [17].
- 1213 Statement of 'Piers', 15 August 2022, 30 [104(a)].
- 1214 Statement of 'Piers', 15 August 2022, 30 [104(a)].
- 1215 Statement of Veronica Burton, 4 August 2022, 5 [22].
- 1216 Statement of Veronica Burton, 4 August 2022, 5 [22].



- 1217 Transcript of Veronica Burton, 22 August 2022, 3097 [44]–3098 [2]; Statement of Veronica Burton, 4 August 2022, 5 [22].
- 1218 Transcript of Veronica Burton, 22 August 2022, 3098 [4–10]; Statement of Veronica Burton, 4 August 2022, 5 [22].
- 1219 Statement of Veronica Burton, 4 August 2022, 5 [22].
- 1220 Transcript of Veronica Burton, 22 August 2022, 3098 [25–33].
- 1221 Transcript of Veronica Burton, 22 August 2022, 3098 [21–33].
- 1222 Transcript of Veronica Burton, 22 August 2022, 3098 [39–42].
- 1223 Statement of Veronica Burton, 4 August 2022, 5 [22].
- 1224 Statement of Veronica Burton, 4 August 2022, 2 [9].
- 1225 Transcript of Veronica Burton, 22 August 2022, 3085 [37–40].
- 1226 Statement of Veronica Burton, 4 August 2022, 2 [10]; Transcript of Veronica Burton, 22 August 2022, 3090 [5–9].
- 1227 Transcript of Veronica Burton, 22 August 2022, 3086 [40]–3087 [7].
- 1228 Statement of Veronica Burton, 4 August 2022, 3 [13]; Transcript of Veronica Burton, 22 August 2022, 3086 [32]–3087 [14].
- 1229 Transcript of Veronica Burton, 22 August 2022, 3085 [14–16].
- 1230 Transcript of Veronica Burton, 22 August 2022, 3085 [8–18].
- 1231 Transcript of Veronica Burton, 22 August 2022, 3089 [35–47].
- 1232 Transcript of Veronica Burton, 22 August 2022, 3085 [43]–3086 [5].
- 1233 Children and Youth Services, ‘Ashley Youth Detention Centre Resident Daily Roll’, December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of ‘Alysha’, 16 August 2022, 40 [203].
- 1234 Children and Youth Services, ‘Ashley Youth Detention Centre Resident Daily Roll’, December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1235 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1236 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1237 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1238 Ashley Youth Detention Centre, ‘Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]’, December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1239 Ashley Youth Detention Centre, ‘Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]’, December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1240 Department of Communities, ‘Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents’, 20 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Children and Youth Services, ‘Ashley Youth Detention Centre Resident Daily Roll’, December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1241 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019.
- 1242 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, December 2019.
- 1243 Statement of Patrick Ryan, 19 August 2022, 27 [249–250].
- 1244 Statement of Patrick Ryan, 19 August 2022, 27 [252].

- 1245 Statement of Patrick Ryan, 19 August 2022, 27 [253].
- 1246 Statement of Patrick Ryan, 19 August 2022, 27 [253].
- 1247 Statement of Patrick Ryan, 19 August 2022, 27 [255].
- 1248 Department of Communities, 'Issues Briefing to the Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1249 Ashley Youth Detention Centre, 'Standard Operating Procedure #8: Supervision and Movement of Young People', August 2012, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1254 Email from 'Alysha' to Pamela Honan, 6 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1255 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 January 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1256 Department of Communities, 'CCTV recording of Franklin 2-1-2020', produced by the Tasmanian Government in response to a Commission notice to produce.
- 1257 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1258 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1259 Statement of 'Alysha', 16 August 2022, 43 [218].
- 1260 Transcript of 'Alysha', 22 August 2022, 3058 [15–22].
- 1261 Statement of Fiona Atkins, 15 August 2022, Annexure M (Email from Nurse Unit Manager to Pamela Honan, 27 July 2022).
- 1262 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 January 2020, 6, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Albert]', 2 January 2020, 6, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 2 January 2020, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1263 Statement of Pamela Honan, 18 August 2022, 42 [65.4].
- 1264 Transcript of Pamela Honan, 19 August 2022, 2963 [2–4].
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- 1266 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 3 January 2020; Ashley Youth Detention Centre, 'Case Notes', 2 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1271 Statement of 'Alysha', 16 August 2022, 43–44 [220].
- 1272 Statement of 'Alysha', 16 August 2022, 43–44 [220]; Email from Alysha to Pamela Honan, 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Alysha to Pamela Honan, 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1273 Email from 'Chester' to Ashley Operations Management, 5 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1276 Email from 'Chester' to Ashley Operations Management, 5 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1277 Email from 'Chester' to Ashley Operations Management, 5 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1278 Email from 'Chester' to Ashley Operations Management, 5 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1280 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 5 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1281 Statement of 'Alysha', 16 August 2022, 23 [109].
- 1282 Statement of 'Alysha', 16 August 2022, 23 [110].
- 1283 Statement of 'Alysha', 16 August 2022, 23 [110].
- 1284 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1285 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1286 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1289 Email from Case Management Coordinator to Operations Manager, 9 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1290 Email from Case Management Coordinator to Operations Manager, 9 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1291 Email from Case Management Coordinator to Operations Manager, 9 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1292 Email from Case Management Coordinator to Operations Manager, 9 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1293 Statement of 'Alysha', 16 August 2022, 14 [65].
- 1294 Request for Statement served on 'Maude', 1 August 2022, 18 [102].
- 1295 Email from Case Management Coordinator to Senior Quality and Practice Advisor, 6 January 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1296 Email from Pamela Honan to 'Alysha', 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Patrick Ryan to Case Management Coordinator, 6 January 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from 'Alysha' to Pamela Honan, 6 January 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1297 Emails from 'Alysha' to Pamela Honan, 6 January 2020, 1–3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1298 Email from 'Alysha' to Pamela Honan, 6 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1299 Email from 'Alysha' to Pamela Honan, 6 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1300 Email from 'Alysha' to Pamela Honan, 6 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1301 Email from Pamela Honan to 'Alysha', 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1302 Email from Pamela Honan to 'Alysha', 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1303 Email from 'Alysha' to Pamela Honan, 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of 'Alysha', 16 August 2022, 45 [231].
- 1304 Email from 'Alysha' to Pamela Honan, 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1305 Emails between 'Alysha' and Pamela Honan, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1306 Email from 'Alysha' to Pamela Honan, 6 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1307 Email from 'Alysha' to Pamela Honan, 6 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1308 Child Safety Service, 'Notification Report Incident Id: [redacted]', 3 February 2020, 4, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1309 Child Safety Service, 'Notification Report Incident Id: [redacted]', 3 February 2020, 4, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1310 Child Safety Service, 'Notification Report Incident Id: [redacted]', 3 February 2020, 4, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1311 Child Safety Service, 'Notification Report Incident Id: [redacted]', 3 February 2020, 4, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1312 Email from Pamela Honan to 'Alysha', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1313 Email from Pamela Honan to 'Alysha', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1314 Email from Patrick Ryan to 'Alysha', 7 January 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1315 Ashley Youth Detention Centre, 'Management Plan in relation to [Ray]', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1316 Ashley Youth Detention Centre, 'Management Plan in relation to [Ray]', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1317 Ashley Youth Detention Centre, 'Management Plan in relation to [Ray]', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1318 Ashley Youth Detention Centre, 'Management Plan in relation to [Ray]', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1319 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1320 Ashley Youth Detention Centre, 'Management Plan in relation to [Ray]', 7 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1321 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]', 4 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1322 Statement of 'Digby', 8 August 2022, 26 [94].
- 1323 Email meeting invite from 'Maude' to Patrick Ryan et al, 8 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1324 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1325 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1326 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1327 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1328 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1329 Email from AYDC staff member to Pamela Honan, 8 January 2020, 1–4.
- 1330 Email from AYDC staff member to Pamela Honan, 8 January 2020, 1.
- 1331 Email from AYDC staff member to Pamela Honan, 8 January 2020, 2.
- 1332 Email from AYDC staff member to Pamela Honan, 8 January 2020, 2.
- 1333 Email from AYDC staff member to Pamela Honan, 8 January 2020, 2.
- 1334 Email from Psychologist, Ashley Youth Detention Centre to former Head of Department, Forensic Mental Health Services and Senior Psychologist, Community Forensic Mental Health Service, 8 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Psychologist, Ashley Youth Detention Centre to former Head of Department, Forensic Mental Health Services, 6 January 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Director of Nursing, Statewide Forensic Mental Health Services to Employee of the Department of Health et al, 13 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Psychologist, Ashley Youth Detention Centre to former Manager, Human Resources, Ashley Youth Detention Centre, 15 January 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 17 [86–89]; Statement of Senior



- Psychologist, Community Forensic Mental Health Service, Department of Health, 22 August 2022, 2 [8]–3 [13]; Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 14 [64], 21 [110].
- 1335 Email from Patrick Ryan to former Operations Coordinator, 22 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Psychologist, Ashley Youth Detention Centre to former Head of Department, Forensic Mental Health Services and Senior Psychologist, Community Forensic Mental Health Service, 8 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Psychologist, Ashley Youth Detention Centre to former Head of Department, Forensic Mental Health Services, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Director of Nursing, Statewide Forensic Mental Health Services to Employee of the Department of Health et al, 13 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email from former Head of Department, Forensic Mental Health Services to Director of Nursing, Statewide Forensic Mental Health Services et al, 13 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Psychologist, Ashley Youth Detention Centre to former Manager, Human Resources, Ashley Youth Detention Centre, 15 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1336 Email from Patrick Ryan to former Operations Coordinator, 22 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Email from former Head of Department, Forensic Mental Health Services to Director of Nursing, Statewide Forensic Mental Health Services, 8 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Director of Nursing, Statewide Forensic Mental Health Services to Nurse Unit Manager, Ashley Youth Detention Centre, 4 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Email exchange between Director of Nursing, Statewide Forensic Mental Health Services and former Head of Department, Forensic Mental Health Services et al, 15 January 2020 to 4 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 18 [97–98]; Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151]; Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 16 [80].
- 1337 Email from former Head of Department, Forensic Mental Health Services to Director of Nursing, Statewide Forensic Mental Health Services et al, 13 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1338 Email from former Head of Department, Forensic Mental Health Services to Director of Nursing, Statewide Forensic Mental Health Services, 13 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1339 Email from Patrick Ryan to former Operations Coordinator, 22 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1340 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 40 [175].
- 1341 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 17 [85].
- 1342 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 4 [13]; Statement of Barry Nicholson, 18 August 2022, 6 [48].
- 1343 Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 4 [18].
- 1344 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 23 [120]–24 [124].
- 1345 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 19 [94–96].
- 1346 Statement of Michael Pervan, 27 July 2022, 47 [88].

- 1347 Statement of Michael Pervan, 27 July 2022, Annexure 27 ('A Memorandum of Understanding between the Correctional Primary Health Services and Children, Youth and Families - Ashley Youth Detention Centre', Department of Communities, May 2021). While this memorandum is dated May 2021, we understand there has been a memorandum in place since 2011 (Statement of Barry Nicholson, 18 August 2022, 6 [46]).
- 1348 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1349 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1350 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1351 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1352 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1353 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1356 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1357 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.
- 1358 Kathy Baker, *Procedural Fairness Response*, 13 July 2023.
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- 1360 Email from former Executive Officer, Strategic Youth Services to Quality Improvement and Workforce Development, 28 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1361 Statement of Pamela Honan, 18 August 2022, 23 [30.6].
- 1362 Statement of Pamela Honan, 18 August 2022, 35 [59.2].
- 1363 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 31, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1364 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 31, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1365 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 31, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1366 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 31, produced by the Tasmanian Government in response to a Commission notice to produce.





- 1391 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 34, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1392 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 35, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1393 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 35, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1394 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1395 Transcript of Veronica Burton, 22 August 2022, 3083 [16–18]; Statement of Veronica Burton, 4 August 2022, 9 [35].
- 1396 Statement of Veronica Burton, 4 August 2022, 9 [35].
- 1397 Transcript of Veronica Burton, 22 August 2022, 3083 [16–18], 3084 [22–25].
- 1398 Transcript of Mandy Clarke, 25 August 2022, 3439 [18]–3450 [7].
- 1399 Transcript of Mandy Clarke, 25 August 2022, 3439 [19]–3450 [7].
- 1400 Transcript of Pamela Honan, 19 August 2022, 2982 [31–34]; Transcript of Mandy Clarke, 25 August 2022, 3437 [10–28].
- 1401 Transcript of Veronica Burton, 22 August 2022, 3079 [4–13]; Statement of Veronica Burton, 4 August 2022, 1 [4]; Statement of former Manager, Serious Event Review Team, 11 November 2022, 3 [10], 13 [60–63].
- 1402 Statement of Ginna Webster, 13 January 2023, 48 [80.1], 53 [89.1].
- 1403 Transcript of Michael Pervan, 26 August 2022, 3525 [47]–3526 [21].
- 1404 Transcript of Michael Pervan, 26 August 2022, 3526 [8–21].
- 1405 Transcript of Michael Pervan, 26 August 2022, 3526 [8–11].
- 1406 Transcript of Michael Pervan, 26 August 2022, 3526 [18–21].
- 1407 Transcript of Michael Pervan, 26 August 2022, 3527 [15–21].
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Commission of Inquiry into  
the Tasmanian Government's  
Responses to Child Sexual  
Abuse in Institutional Settings

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

Volume 5: Children in youth detention  
Book 2

August 2023

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

**Volume 5**  
**Children in youth detention (Book 2)**

**The Honourable Marcia Neave AO**

President and Commissioner

**Professor Leah Bromfield**

Commissioner

**The Honourable Robert Benjamin AM SC**

Commissioner

August 2023

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### **Content warning**

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

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

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# 11 Case studies: Children in youth detention (continued)

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## Case study 3: Isolation in Ashley Youth Detention Centre

### 1 Overview

The inappropriate isolation of children and young people in detention is a breach of their human rights. It is well recognised that isolating a child or young person adversely affects their mental health and wellbeing. In recognition of the harm isolation can cause, the *Youth Justice Act 1997* ('Youth Justice Act') and Ashley Youth Detention Centre policies and procedures outline strict requirements for when isolation can be used in the Centre. It must never be used as punishment.

We heard about multiple practices at the Centre that involved at least some isolation of young people. However, these practices were not formally labelled as 'isolation' or responded to in line with the requirements for the use of isolation. Examples of the labels used were:

- routine Centre-wide 'time out' or 'quiet time'
- 'unit bound'
- 'individualised programs'

- ‘segregation’
- non-association
- the ‘Blue Program’.

As outlined below, it appears to us that at least occasionally, these isolation practices involved locking a young person alone in their unit or their room and operated outside the isolation procedures. The evidence indicates these practices also involved segregating young people for days or weeks at a time from:

- the routine of the Centre
- programs and education
- their peers.

Irrespective of the name used, and perhaps slight differences between each practice, from a child’s perspective, these were isolation practices. The effect on their mental health and wellbeing would have been the same. For this reason, we refer to these practices as isolation practices.

Often, these isolation practices were connected to the Behaviour Development System at Ashley Youth Detention Centre. As discussed in Chapter 10, the Behaviour Development System (now known as the Behaviour Development Program) is an incentive-based behaviour management protocol that allocates privileges or restrictions to a young person based on a colour coding—green, yellow, orange or red—that corresponds with their level of ‘good’ or ‘bad’ behaviour as judged against a set of criteria. As described in Chapter 10 and below, isolation practices were often used with ‘bad’ colour ratings corresponding to ‘bad’ behaviour.

The inappropriate use of isolation practices over many years speaks to organisational factors the National Royal Commission identified as relevant to the risk of child sexual abuse in youth detention. We discuss these factors in Chapter 10, but particularly relevant in this context are:

- the use of strict rules, discipline and punishment
- cultures of disrespect for children
- cultures of humiliating and degrading treatment of children
- cultures where children’s voices are not encouraged, and their welfare is not prioritised
- group allegiance among staff and among managers.<sup>1531</sup>

When isolating young people at Ashley Youth Detention Centre is unauthorised, unregulated and unreported, the risk of, and opportunities for, the physical and sexual

abuse of young people increases. Such belittling and dehumanising practices also reduce the likelihood of children and young people making disclosures of child sexual abuse because their sense of what is right and wrong, trust in adults at the Centre, and self-worth have been undermined.

We also heard about other forms of isolation—such as ‘restrictive practices’ and ‘lockdowns’—that involved all children in the Centre being restricted to their units or rooms for operational reasons. These practices were often a result of staff shortages rather than targeted actions to manage specific children. We are conscious these practices are isolation by another name, are human rights abuses, and have the same impact as other isolation practices on children’s health and wellbeing, although we do not address them in this case study. We discuss our concerns about staff shortages and our recommendations for increasing staffing numbers in Chapter 12.

In this case study, we briefly summarise the law and policies relating to isolating children and young people in detention, highlighting that the use of isolation is intended to be strictly regulated and monitored. We then outline what we heard about detainees’ experiences of isolation, drawing from the victim-survivor accounts we provide in Case study 1. We then discuss how various forms of isolation practices were adopted over many years at Ashley Youth Detention Centre, often, we suspect, with the knowledge of Centre management, the Department, and the Tasmanian Government at the time. We conclude with several findings about the inappropriate isolation of children and young people at the Centre, namely that:

- the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today
- the Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action
- there was a consistent failure to include the voices of children and young people detained at Ashley Youth Detention Centre in any reviews, investigations or policy changes relating to isolation
- Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices.

This case study covers a series of concerning allegations against Ashley Youth Detention Centre staff. We acknowledge there have been and are staff at the Centre who have sought to do their jobs lawfully and appropriately. References to problematic practices by ‘staff’ in this case study are not intended as a reference to all staff at the Centre, unless explicitly stated in a specific context.

## 2 The law and policies

As outlined in Chapter 10, disciplinary measures involving ‘placement in a dark cell, solitary confinement or any other punishment that may compromise the physical or mental health or wellbeing of the child’ violate article 37 of the United Nations Convention on the Rights of the Child and are strictly prohibited.<sup>1532</sup>

The Youth Justice Act and Ashley Youth Detention Centre’s isolation policy, the *Use of Isolation Procedure* dated 1 July 2017 (‘Isolation Procedure’), recognises the seriousness of isolating a child or young person by limiting the practice to certain situations.<sup>1533</sup> Overall, these instruments show there are strict requirements for subjecting a child to isolation in the Centre to protect them from the harm this practice causes. We understand similar strict requirements have existed in previous iterations of isolation procedures. In this section, we outline the requirements set out in these instruments as context for the isolation practices discussed in subsequent sections. We also show that when practices that amount to isolation are not recognised as such, these protections are not provided to children and young people in detention.

The Youth Justice Act defines ‘isolation’ as ‘locking a detainee in a room separate from others and from the normal routine of the detention centre’.<sup>1534</sup> What constitutes the ‘normal routine’ of a detention centre is not defined in the Youth Justice Act. Tasmanian courts have not substantively considered it.

Combined, the Youth Justice Act and the Isolation Procedure provide that:

- Isolating a detainee is only permissible if their behaviour poses an immediate threat to the safety of themselves, another person or property, or it is in the interest of the security of the Centre, and when all other reasonable steps have been taken to ‘prevent the harm’.<sup>1535</sup> Isolation as a form of punishment does not satisfy one of these purposes.
- Isolation should be for the ‘minimum time necessary to ensure the safety of individuals or property’, with a goal of reintegrating the young person ‘into the group as safely and as quickly as possible’.<sup>1536</sup>
- There are strict requirements about who in the Centre can authorise isolation, being the Centre Manager or their delegate, and for what time periods.<sup>1537</sup>
- There are strict requirements for the level of supervision and observation of children and young people in isolation.<sup>1538</sup>

Below, we discuss several occasions where isolation or related practices were used in response to Centre-wide ‘incidents’. The Isolation Procedure offers examples of situations where isolation might be authorised in the interests of Centre security. These examples include:



- to prevent or control a security breach, including incidents such as, but not limited to:
  - a riot
  - a power failure
  - a perimeter breach
  - an escape or attempted escape
- to allow order or control to be restored to the Centre (or to prevent its anticipated loss).<sup>1539</sup>

These examples suggest that isolation must only be used in the interests of the security of the Centre in the most serious of situations. The Isolation Procedure explains that such incidents ‘may result in more than one young person requiring isolation at a time, or the entire Centre being locked down’.<sup>1540</sup>

The Isolation Procedure requires that an authorisation of isolation must be given at the time the decision to isolate the young person is made; that is, not before the decision, afterwards, or on the condition that certain events occur.<sup>1541</sup> The Centre Manager must be satisfied ‘that isolation is a reasonable intervention under the circumstances’, and that its use will comply with both the Youth Justice Act and the Isolation Procedure.<sup>1542</sup> The Centre Manager must assess and determine the conditions for the care and treatment of the young person while in isolation. They must also consider the particular needs and circumstances of the child or young person.<sup>1543</sup>

The Centre Manager sets the conditions of isolation, including the period of isolation and the observation schedule.<sup>1544</sup> Other conditions may include specifying items that are safe and therapeutic to be left with the young person, for example, ‘playing cards, reading material or drawing material’, and access to a support person, cultural advisor, or youth worker.<sup>1545</sup>

Once isolation is authorised, the Operations Coordinator at the Centre must ensure, among other things, the young person is advised:

- why they are being isolated
- their period of isolation
- how they can seek help while they are isolated.<sup>1546</sup>

The Youth Justice Act does not prescribe a maximum period of isolation. The Isolation Procedure sets out tiered maximum isolation periods. It requires the Centre Manager to ‘seek to set the shortest period of isolation that is appropriate in the circumstances’.<sup>1547</sup> The Isolation Procedure prescribes the following periods of isolation:

- an initial period of no more than 30 minutes, which an Operations Coordinator can authorise
- an extension of the initial period to three hours (including the first 30 minutes), which the Centre Manager (or their delegate) must authorise.<sup>1548</sup>

The Isolation Procedure allows for the period of isolation to be extended to a maximum of 12 hours.<sup>1549</sup> To extend isolation beyond three hours, the Centre Manager must:

- review the observation records prepared during the isolation period
- consult with the Correctional Primary Health Services nurse and/or medical practitioner and available members of the Multi-Disciplinary Team
- consult with the Director, Strategic Youth Services on the outcome of the discussion with the Correctional Primary Health Services nurse, medical practitioner and/or Multi-Disciplinary Team members<sup>1550</sup>
- complete the 'Authorisation for Extension of Isolation' form, noting any new conditions of the isolation or change to conditions.<sup>1551</sup>

The Youth Justice Act and the Isolation Procedure require the Centre Manager to set a schedule for observing young people in isolation, with observations to occur at intervals of no more than 15 minutes.<sup>1552</sup> The Isolation Procedure requires shorter intervals where there are particular concerns about a young person's wellbeing.<sup>1553</sup> For example, young people who may be at risk of self-harm must be subject to observation intervals in line with the relevant suicide and self-harm procedure.<sup>1554</sup>

At the time of the 2019 roof incident that we discuss later in this case study, the relevant instrument of delegation provided that the power to isolate a detained young person under section 133(2) of the Youth Justice Act (and therefore to extend the period of isolation) was delegated to the Operations Manager or the Director, Strategic Youth Services, only 'if the Detention Centre Manager is on leave, is uncontactable, or is unable for any other reason to perform the relevant function'.<sup>1555</sup> The Operations Coordinator and youth workers 'performing the duties of the Operations Coordinator' also had the power to isolate a detained young person for up to 30 minutes (but no more).<sup>1556</sup>

In 2021, the delegation instrument was revised. The most critical change regarding isolation was that the Assistant Manager could exercise, without any conditions, the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act.<sup>1557</sup>

In addition, the Isolation Procedure places obligations on the staff member(s) observing the isolated young person, including to:

- speak to the young person
- assess whether their mental health has deteriorated

- assess if the young person still poses an immediate threat to themselves, others, or the security of the Centre
- record their observations.

If circumstances change, they must take appropriate steps.<sup>1558</sup> Any engagement between the young person and the observing staff member(s) does not bring the isolation period to an end or restart the time limits.<sup>1559</sup>

Consistent with the legislative requirement that isolation only be used as a short-term tool to address immediate safety or security concerns, the Isolation Procedure requires consideration to be given to ending isolation as soon as the young person's behaviour has sufficiently settled, or isolation is no longer necessary in the interests of the security of the Centre, irrespective of the set isolation period.<sup>1560</sup>

At the end of a period of isolation, the Operations Coordinator must check the 'Authorisation for Isolation Form' to determine what post-isolation conditions have been set.<sup>1561</sup> If considered necessary, the Operations Coordinator or Centre Manager must put a post-isolation plan in place to address matters such as:

- the implementation of post-isolation conditions
- the level of observation required for the young person as they resume their normal routine
- a review of behaviour goals and strategies to prevent further periods of isolation.<sup>1562</sup>

Debriefings with other young people and staff should also occur if required.<sup>1563</sup>

The Operations Coordinator or youth worker must also inform the young person when their isolation has ended.<sup>1564</sup>

### 3 What we heard from victim-survivors about isolation practices at Ashley Youth Detention Centre

We heard evidence about isolation practices at Ashley Youth Detention Centre from young people who had been detained there, and their families. Those young people described the circumstances in which isolation was used at the Centre, the length of isolation incidents, and the conditions under which they were held in isolation. The accounts we received referred to various periods of detention during the past two decades, when individuals were aged between 11 and 17 years. As noted earlier, it was not possible for our Commission of Inquiry to test the veracity of all allegations of abuse, but we identified many common themes in the accounts we heard.

Some experiences shared by victim-survivors included their recollections of:

- different degrees or kinds of isolation, ranging from being held in a cell alone to being confined to a unit<sup>1565</sup>
- long periods of isolation, including for several weeks<sup>1566</sup>
- inappropriate isolation used for a range of reasons, including as part of the induction process, as punishment for bad behaviour or self-harm, against victims of assault or as retribution for making complaints<sup>1567</sup>
- being isolated, or isolating themselves, to keep themselves safe from other young people<sup>1568</sup>
- poor isolation conditions, often with limited or no access to therapeutic programs, education and health care, or without appropriate bedding and sufficient food<sup>1569</sup>
- handcuffs and physical restraints being used to place a young person in isolation, or while they were in isolation<sup>1570</sup>
- isolation traumatising and confusing young people, contributing to long-term negative effects on a young person's mental health and wellbeing.<sup>1571</sup>

We heard that many new arrivals to the Centre were isolated as part of the induction process. Ben (a pseudonym) told us that when he first arrived at the Centre in the early 2000s, he was placed in a 'holding cell' for 72 hours of mandatory observation, where he was given only a mattress and a thin blanket.<sup>1572</sup> Simon (a pseudonym) told us that when he arrived at the Centre for the first time in the mid-2000s, he was locked in a cell for two days.<sup>1573</sup> Erin (a pseudonym), who was at the Centre in the mid-2010s, some years after Ben and Simon, described how she was 'unit bound' by herself for about a week each time she was admitted as 'part of the normal introduction', and that she was only allowed out for one or two hours per day during that time.<sup>1574</sup> She said this experience resulted in 'massive trauma', that now she 'can't deal with being trapped inside' and that she 'found the COVID lockdowns really hard'.<sup>1575</sup>

We were told that, besides being a feature of the admissions process, isolation was sometimes used to punish young people. Simon described how he was placed in isolation two or three times after committing detention offences, refusing to go to bed when directed or not listening to staff.<sup>1576</sup> He recalled that staff members would say he was being isolated as punishment for those behaviours.<sup>1577</sup>

We heard concerning evidence about isolation being used against detainees as punishment for complaining or when a young person was assaulted.<sup>1578</sup> Fred (a pseudonym), who first went to the Centre in the mid-2000s, described two incidents where he was 'locked down' as punishment after being assaulted by other young people. He told us this was a 'pretty normal' response to assaults.<sup>1579</sup> Fred said that 'several' times it was only him who was 'locked down', not those who had assaulted

him, and that he was told this was because he ‘was an annoyance to the unit’.<sup>1580</sup> Erin also described being kept in her room because of threats of assault made against her by other young people.<sup>1581</sup>

Brett Robinson, who was detained at Ashley Youth Detention Centre in the late 2000s, described his experience in a similar way:

When you were locked down, they would come in to your cell at 8.00 am in the morning, take all of your bedding away and then give it back to you at the end of the day. You were not able to do any programs or school. You weren’t allowed to watch TV. They would take out any excess stuff that was considered a privilege. You’d be left with a book or two and maybe a puzzle.<sup>1582</sup>

Erin told us that sometimes when staff locked young people in their room over the weekend, they would make the isolation worse by disorienting them:

They would tell you that it was six o’clock in the morning when it was actually ten o’clock. They would leave a curtain up over your door so you couldn’t see the sun and didn’t know what was going on around you. You’d miss out on your lunch and they wouldn’t let you out of your cell until one o’clock in the afternoon. They did these things to mess with you and make your life really hard.<sup>1583</sup>

Some victim-survivors told us that, while in isolation in the early to late 2000s, they would often only be allowed an hour a day to make a phone call or to exercise.<sup>1584</sup> One witness described how, in the mid-2000s, they only had access to a bucket as a toilet.<sup>1585</sup> Another said, in the early to mid-2000s, staff members would first ‘bash’ him up before placing him in a ‘freezing cold’ cell.<sup>1586</sup>

We also heard young people were sometimes physically restrained when being placed in isolation, or once in isolation.<sup>1587</sup> Brett Robinson, who was first admitted to the Centre in the late 2000s said:

I was hog tied and left in my cell, then put into lockdown. I [brought] it up in the weekly meeting. The staff responded by saying, ‘If you want to misbehave, then there are steps put in place to deal with you’. When the workers who hog tied me came back on shift, they just laughed and said, ‘What did you think was going to happen?’<sup>1588</sup>

Two witnesses told us that, after attempting suicide, they were held in isolation, were subjected to further physical or psychological abuse by guards and were not provided with any counselling assistance. Ben, who was at the Centre from the early to mid-2000s, said that after stealing medical supplies with other young people and attempting suicide, he was stripped naked, flogged and ‘locked down on 23-hour-a-day lockdowns for weeks on end’.<sup>1589</sup> Ben recalled that, once he was released from lockdown, he was on and off the ‘non-association program’, which meant being locked down for 23 hours a day with a book, pen, pad, mattress and bedding.<sup>1590</sup>

Charlotte (a pseudonym), who was first admitted to the Centre in the early 2000s, told us that, after a confrontation with a staff member at the Centre, she was locked in her cell for four days.<sup>1591</sup> At the start of her isolation, she set her cell on fire and attempted suicide. She recalled:

After about 10 minutes the room filled up with smoke ... The sprinklers went off, but no one came for ages. Then they just opened the viewing panel in the door. They could see me in the shower with blood on my arms and just left me there. I was in that room alone for 4 days ... I got water and toast for tea. I was wet from the sprinkler ... I didn't have any bedding. I had to wear the wet, burnt, smelly clothes. When they finally came to get me a few days later they ... stripped me down to nothing with 2 female staff. ... Then they finally gave me some clothes and left me alone again all night until the next day. Then I was sent back to the unit and locked down for a week ...<sup>1592</sup>

Charlotte said she was upset, hungry and confused during her isolation and again attempted suicide.<sup>1593</sup>

We heard of a family member's perception that her attempts to limit the use of isolation practices on her child seemed to make things worse for him. Eve (a pseudonym) described how her son Norman (a pseudonym), who was first admitted to the Centre in the early 2010s, was 'in lockdown all the time', with limited exercise and sunlight.<sup>1594</sup> She was concerned these practices were having a negative effect on Norman's mental health.<sup>1595</sup> Eve said trying to raise the issue with management at the Centre appeared to have negative consequences for Norman. One such consequence was being placed on frequent self-harm observations.<sup>1596</sup>

These accounts were deeply troubling to us, particularly given the consistency across accounts and the patterns that emerged, because they suggested that during the early 2000s to at least the mid-2010s, unlawful and harmful isolation practices were part of how children and young people detained at the Centre were commonly treated.

## 4 Practices that involve isolation

Two of the most common isolation practices we heard about that operated outside the formal policy framework for isolation at Ashley Youth Detention Centre were 'unit bound' and the 'Blue Program'. We heard about these isolation practices, which often operated outside the policy framework, being used up to early 2020 (noting we also heard about restrictive practices for operational reasons, which amount to isolation, due to the COVID-19 pandemic and staff shortages from 2020 to 2023).

## 4.1 The practice of ‘unit bound’

The unit bound practice appears to have a long history at Ashley Youth Detention Centre. However, we could not identify a specific policy on unit bound or any formal definition of the practice.

We received confusing evidence about what constituted unit bound. One long-term staff member told us the unit bound practice was governed by a ‘combination’ of policies and procedures.<sup>1597</sup> Two other long-serving staff members told us the policy that governed the Behaviour Development System also governed the use of the unit bound practice.<sup>1598</sup> Madeleine Gardiner, former Manager, Professional Services and Policy at Ashley Youth Detention Centre, said she was ‘not aware’ of a specific policy relevant to unit bound, and the practice appeared to be based on a ‘case-by-case’ assessment of the security risk associated with the young person being in the shared areas of the Centre.<sup>1599</sup>

We put a series of questions to past and present staff of the Centre about the:

- rationale or criteria for the use of the unit bound practice
- nature of its operation
- difference between being unit bound and being in isolation under the Centre’s Isolation Procedure.

The responses we received were, at best, inconsistent.

In her evidence to us, Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, described the unit bound practice as a temporary response to a young person’s escape risk, that is, where they had attempted to escape, actually escaped or said they intended to escape from the Centre.<sup>1600</sup> This rationale was echoed by some other Centre staff.<sup>1601</sup> Another staff member described a sliding scale of risk. They said a young person would be isolated in their room when they presented as a risk to themselves, others or the Centre, but the unit bound practice would be used in cases of lesser risk, where separating a young person from others was still considered necessary for safety.<sup>1602</sup> Another staff member said repeated threats or attempts to assault other young people were identified as possible reasons for using the unit bound practice.<sup>1603</sup>

We understand a decision to place a young person on unit bound was usually made by the Centre Support Team at the Centre.<sup>1604</sup> Ms Gardiner said the decision to put a young person on unit bound was made by the Operations Manager, the Centre Manager, the Operations Coordinator, or the Centre Support Team.<sup>1605</sup> The Centre Support Team also decided a young person’s rating under the Behaviour Development System, either during weekly meetings or at ad hoc interim meetings.



In terms of the practical operation of the unit bound practice, Ms Atkins said being unit bound meant the young person had access to unit-based activities, underpinned by an ‘individualised program’ prepared by a program coordinator.<sup>1606</sup> It appears the nature and content of any ‘individualised program’ was a matter of discretion. There was a degree of inconsistency in the evidence we received as to the extent to which the young person would have access to common areas of the unit, Ashley School, the gym and outdoor areas.<sup>1607</sup>

Samuel Baker, Principal of Ashley School, told us that a young person’s colour level (sometimes referred to as status or rating) on the Behaviour Development System affected the number of hours of face-to-face schooling they received each day, and the nature and content of that schooling. He said young people who were unit bound due to a red colour rating could not attend woodwork, art and ‘fit gym’—because equipment in those classes could be used as a weapon—but could continue to attend all other classes.<sup>1608</sup> Those young people were required to remain unit bound when school activities, such as woodwork, were scheduled.<sup>1609</sup> We also heard from staff at the Centre that young people who were unit bound were not permitted to attend school until they agreed to not behave in the ways that caused them to be placed on unit bound.<sup>1610</sup>

There was a lack of clarity in responses about the degree to which young people who were unit bound were physically isolated from their peers. Pamela Honan, Director, Strategic Youth Services, described the unit bound practice as one ‘where a young person is allowed out of their room but they are still contained within the confines of a locked unit’.<sup>1611</sup> Ms Honan acknowledged she was unclear whether young people on unit bound were allowed to associate with other young people within the confines of the unit. She agreed the unit bound category appeared to be ‘a form of isolation by another name’.<sup>1612</sup> Ms Gardiner was more certain in her characterisation. She contended that unit bound involved ‘isolating people from the general routine of the Centre’ or the ‘general activities of the Centre’, as well as from their peers.<sup>1613</sup>

## 4.2 The Blue Program

We understand that from early 2011 to December 2013, Ashley Youth Detention Centre had what was commonly referred to as a Blue Program.<sup>1614</sup> It was also formally reintroduced for a short period (at least three months) in 2019 with the knowledge of the Department (refer to Section 9 of this case study). As will become apparent throughout this case study, the Blue Program appears to have been adopted informally at other times, possibly as the unit bound practice.

One version of the Behaviour Development System (dated 2013) referred to the blue category in that system as ‘full segregation’ and outlined that:<sup>1615</sup>

This colour level is for those young people who are unable to function under the normal provisions of the BDS [Behaviour Development System] and require an intensive level of supervision, such as full segregation from other young people. Refer Intensive Support Program ISP ...

Young people on this level would currently pose an immediate threat to the security and safety of the Centre including both staff and young people. This would include such things as attempt[ed] or complete absconding, assaultive behaviour, possession of a lethal weapon or facsimile of a lethal weapon or persistent history of contraband possession and/or use. Their behaviour may also be considered to be a primary source of inciting other young people to behave in a way that is subversive and/or disruptive to the order of the Unit/Centre.<sup>1616</sup>

Evidence received from staff at the Centre suggests the Blue Program involved at least some form of isolation. At our public hearings, Sarah Spencer, a youth worker at Ashley Youth Detention Centre, acknowledged the Blue Program ‘involved a lot of isolation’.<sup>1617</sup> One staff member told us that a young person on the Blue Program was ‘in isolation for up to [eight] hours at a time’.<sup>1618</sup>

Some previous staff told us the Blue Program and ‘unit bound’ were essentially the same practice. However, it is important to note that unit bound practices were not limited to periods when the Blue Program was officially in operation. As Ms Gardiner explained:

My understanding is that ‘Unit Bound’ and being on colour ‘Blue’ on the [Behaviour Development System] was the same, which I learnt from an email from Patrick Ryan [Centre Manager] on [4 September 2019] ... that was a response to the Commissioner for Children explaining that for a young person to be ‘Unit Bound’ was part of the Blue colour of the Behaviour Development System (BDS). This definition of Blue and ‘Unit Bound’ was never communicated clearly to myself until this time. My understanding and observation of the ‘Unit Bound’ or ‘Blue colour’ was that a young person was not in isolation but was confined to the unit for parts of the day, they did not participate in the general activities of the Centre, and they received individual timetabling of activities. I understood that the young person was escorted to use the gym or other areas of the Centre, when it was possible to do this, to ensure the safety of the Centre was not compromised. I am not completely clear on the parameters of ‘Unit Bound’ practices, as there was no policy/procedure at the time regarding a detainee being ‘Unit Bound’ and as can be seen in the response to the Commissioner for Children, this practice was used at the discretion of the Centre Manager, to maintain safety and security of the Centre.<sup>1619</sup>

Alysha (a pseudonym), former Clinical Practice Consultant, who started working at Ashley Youth Detention Centre after the Blue Program ceased official operation (for the second time) in 2019, noted that staff continued to conflate the Blue Program with the unit bound practice.<sup>1620</sup> Alysha observed that:

Whilst the blue category was not part of the systems practice manual while I was at the Centre, it was regularly referred to and seemingly accepted as a standard practice despite occasionally being acknowledged as something that should

not be said. I was present at [Centre Support Team] meetings where Operations staff would discuss putting children ‘on the Blue Program’. It would be noted that ‘we can’t say that anymore’, so the meeting minutes would reflect that the child was either ‘unit bound’ or on an ‘individual support program’.<sup>1621</sup>

Ms Spencer also told us staff referred to the Blue Program, even though it was not officially in operation. When asked if the Blue Program was reintroduced in 2019, she said:

I don’t know that I’m officially aware of that. I don’t think so. As in, how recent? ...

I don’t think so. I think there was some isolation around a riot, but I don’t believe that it was an official Blue Program. People around the Centre may have used that word just because that’s what they related it to because of their previous history, but I don’t think it was officially called that, I think it was just in regards to managing these particular young people that had a pretty serious riot.<sup>1622</sup>

## 5 Concerns raised about the Blue Program in 2013

On 12 September 2013, Deputy Chief Magistrate Michael Daly delivered judgment in the case *Lusted v ZS*.<sup>1623</sup> The judgment included significant criticism of the operations of Ashley Youth Detention Centre, in particular the use of isolation and similar practices. Following the sentencing of the young person in that case (referred to as ‘ZS’ or ‘Z’) for assaulting a staff member at the Centre, Deputy Chief Magistrate Daly thought it appropriate and necessary to make further comments regarding Z’s experiences at the Centre while on remand. The need for these comments arose because during proceedings, Z disclosed he had been locked in his room for three weeks as punishment for destroying property.<sup>1624</sup>

The comments of Deputy Chief Magistrate Daly in *Lusted v ZS* are relevant to the use of isolation and similar practices at Ashley Youth Detention Centre. Deputy Chief Magistrate Daly expressly stated in *Lusted v ZS* that the Court’s understanding of ‘the colour scheme’ (being the Blue Program and the Behaviour Development System) was minimal.<sup>1625</sup> The Court received no information of ‘practical value’ about the system beyond the experiences of the young person in question in the case.<sup>1626</sup> However, Deputy Chief Magistrate Daly noted it would be a ‘very serious issue of grave concern’ if a young person had been isolated outside the ‘strict provisions of [section] 133’ of the Youth Justice Act.<sup>1627</sup>

Deputy Chief Magistrate Daly issued a series of questions to the then Secretary of the Department on 26 July 2013 about whether Z’s experiences at the Centre may have constituted abuse or neglect.<sup>1628</sup> These questions related to factual issues, such as whether Z had been confined to his room and the circumstances of that confinement, and clarification about whether that confinement and the Blue Program constituted isolation for the purposes of the Youth Justice Act.<sup>1629</sup>

Child Protection Services, on behalf of the Secretary, responded to these questions on 30 July 2013. Part of its response was as follows:

[The Blue Program] does not involve the isolation of a young person. Neither is it a punishment. It is a Program put in place where a young person is able to function under the normal provisions of the Behaviour Development System and requires an intensive level of supervision and support. It may limit the access for the young person involved to some areas of the facility and it may involve periods of segregation from other residents.<sup>1630</sup>

It is apparent to us that the response did little to clarify the specific experiences of Z or the broader issue. The response appears to suggest that because the Blue Program was part of the Behaviour Development System, which was part of the 'routine' of the Centre, a young person under the Blue Program was not in isolation. The response provided no clarification on what meaningful distinction, if any, existed between confinement or 'segregation' of a young person under the Blue Program in response to adverse behaviours and the use of isolation as punishment. Indeed, after seeking further clarification, to which the Department provided no response, Deputy Chief Magistrate Daly stated in his judgment that the Secretary's initial response was 'so vague that it was of no practical value' and 'wholly inadequate'.<sup>1631</sup>

Consequently, Deputy Chief Magistrate Daly said in his decision that:

In relation to Z's isolation, for the purposes of this exercise it is open to me to conclude that what happened to Z while in the custody of the Secretary was that he was placed in isolation in a manner unauthorised by the *Youth Justice Act 1997*, [section] 133. Further, on the material before me, I fear that unauthorised isolation may [be] a normal part of the management of youths in detention or on remand.<sup>1632</sup>

Deputy Chief Magistrate Daly was further critical of the Secretary's approach to addressing concerns raised by authorities outside Ashley Youth Detention Centre regarding the use of isolation, as well as the use of practices that are substantively isolation being applied outside the statutory framework.

We note these criticisms are highly relevant to subsequent events at the Centre in the years that followed the decision of *Lusted v ZS*.

## 5.1 Our observations

We conclude that from 2013, the Department and, we presume, the Tasmanian Government were made aware and put on notice of isolation practices that contravened Tasmanian law and human rights principles to which Australia was a signatory, with concerns raised that these were not one-off but routine practices.

## 6 Concerns raised about unit bound and similar practices in 2016 and 2017

During his time as Commissioner for Children and Young People, Mark Morrissey raised the issue of isolation with the Department, including what he viewed as substantively similar practices referred to by other names.

In April 2016, in a letter to the then Secretary of the Department, Michael Pervan, Mr Morrissey raised concerns that isolation was being used as a form of punishment against young people in detention.<sup>1633</sup> Specifically, Mr Morrissey relayed complaints he had received from two young people in detention that they had been kept in isolation for a week as punishment for their involvement in an incident at the Centre.<sup>1634</sup> In the letter, Mr Morrissey expressed his clear disapproval of the practice. He stated that it ‘would be reasonable to conclude’ that the young people had been isolated ‘contrary to various international and national standards’. He also noted that concerns about isolating young people in detention had previously been raised in 2013 (in relation to the isolation of Z, discussed above).<sup>1635</sup>

Later in April 2016, a Minute to the Secretary with the subject line ‘[Ashley Youth Detention Centre] – Commissioner for Children letter and emerging concerns’ was drafted by staff in Children and Youth Services and provided to Secretary Pervan. Secretary Pervan approved the Minute on 6 May 2016.<sup>1636</sup> The Minute noted that:

- the Commissioner for Children and Young People had formally advised the Secretary of concerns relating to the use of isolation as a punishment at Ashley Youth Detention Centre
- the Deputy Secretary, Children and Youth Services, had previously raised concerns surrounding staff capability at the Centre
- the Director, Services to Young People (this role later became Director, Strategic Youth Services), had also recently identified major challenges at the Centre, including in relation to the culture of the Centre, which was considered to influence how staff members responded to the behavioural issues of young people in detention.<sup>1637</sup>

In the Minute, Secretary Pervan was advised that the then Deputy Secretary and Director had undertaken an informal preliminary assessment of the matters raised by the Commissioner for Children and Young People, and ‘consider[ed] it likely that the claims of the children and the concerns of the Commissioner are accurate’.<sup>1638</sup> Further, the then Director had determined that:

- many staff at Ashley Youth Detention Centre had been in their roles ‘in excess of 15 years’

- there was a negative culture at the Centre, with some staff subscribing to a punitive approach when dealing with young people
- the delivery of therapeutic care to young people, and adherence to their human rights, had not evolved at the Centre so as ‘to meet the requirements of a modern detention centre and community expectation’
- the Centre’s internal complaints mechanism framework was inefficient, not transparent, and did not include a formal register or a review process for complaints.<sup>1639</sup>

The Minute appeared to suggest considerable concern about the practices of current staff. It recommended with some urgency, that a ‘profiling of required skill base’ for staff be undertaken with human resources involvement ‘to ensure rules surrounding staffing and any profiling of positions affords natural justice and procedural fairness and are undertaken in line with rules of the State Service’.<sup>1640</sup> We infer from these statements that the authors were recommending an effective spill of staff positions, which is an exceptional recommendation for a Deputy Secretary and a Director within a Department to make. The Minute also recommended establishing an ongoing mandatory training calendar.

The Minute stated the issues identified regarding isolation practices ‘have remained embedded at [the Centre] for a significant period’ and that ‘[c]onsistent concerns have been raised over a number of years, by a number of stakeholders’.<sup>1641</sup> The Minute stated that in June 2013, the Secretary at that time had instigated a ‘Taskforce’ for Ashley Youth Detention Centre to identify and implement changes that would ‘improve the day to day lives of the young detainees’. The Minute stated that the Taskforce made 16 recommendations, including ‘removing “quiet time” for residents twice a day where they are confined to their room’.<sup>1642</sup>

The Minute further noted that in 2015, a review into the governance and management arrangements at the Centre identified shortfalls in leadership, culture and the capacity of staff.<sup>1643</sup> In response to the review, the Government had agreed to multiple actions, including that the practice of ‘Time Out’—which the Minute stated ‘equates to Isolation at law’—be ceased, and that staff at the Centre were to ‘work across teams when requested to do so rather than working solely in the allocated smaller team groups’.<sup>1644</sup>

The Minute recommended that Secretary Pervan approve and resource an immediate ‘change management process’ at the Centre to introduce a therapeutic model and associated training for staff, as well as new governance structures to ensure the Centre’s operations met legislative requirements.<sup>1645</sup>

The Minute further recommended to Secretary Pervan that immediate action be taken to:

- review policies and procedures relating to ‘time out’, isolation and behaviour management in line with best practice across other jurisdictions, legislative requirements, and requirements under various national and international human rights treaties and conventions
- consider a formal change management model to help Centre staff understand where ‘[d]etention in Tasmania needs to move to’
- review and amend the internal complaints framework to direct all complaints from young people to the then Director in the first instance, who could record complaints in a formal register and review and monitor systemic issues at the Centre
- develop a formal register in relation to incidents of isolation to ensure compliance with the law
- investigate whether young people in detention were receiving the same level of education as young people engaged in mainstream education
- develop programs that create pro-social pathways after school hours and on weekends for young people in detention
- implement outstanding actions from previous reviews relevant to the treatment of young people in detention.<sup>1646</sup>

The Minute concluded that, should immediate efforts to reform the Centre not occur, there was a significant risk to the reputation of the Department and the Minister, as well as a ‘strong prospect of litigation for human right breaches or failures to comply with legislative obligations’.<sup>1647</sup> The Minute emphasised to the Secretary that:

Without purposeful effort to support true quality of care in detention for the youth of Tasmania under strong and contemporary leadership, it is unlikely that significant change requirements could succeed.<sup>1648</sup>

We note that, in an undated letter to Mr Morrissey in response to issues raised in his letter of 6 April 2016, Secretary Pervan did not substantively address the issue of isolation. Secretary Pervan observed the matters raised in Mr Morrissey’s letter were not isolated incidents but likely to be ‘systemic and embedded within all interactions between the staff and young people’.<sup>1649</sup> In his letter to Mr Morrissey, Secretary Pervan did not relate the Department’s observations there were likely human rights breaches occurring at the Centre. We consider this a missed opportunity to transparently recognise the potential harm being done to children and young people at the Centre. Such recognition and engagement are important to enable a Commissioner for Children and Young People to perform their function appropriately.



On 9 November 2016, Mr Morrissey emailed the Acting Deputy Secretary, Children and Youth Services, and other departmental officials after reviewing the Ashley Youth Detention Centre daily roll and noticing two young people were listed as ‘unit bound’.<sup>1650</sup> Mr Morrissey sought clarification regarding the conditions the young people experienced while being unit bound, particularly whether they were locked in their rooms, separated from other young people (young people who were in the same unit and in the Centre more broadly), excluded from school or other programs and made to eat meals separately.<sup>1651</sup>

On 10 November 2016, the Acting Deputy Secretary, Children and Youth Services replied to Mr Morrissey, stating the term ‘unit bound’ was used to describe the placement of a young person on a ‘separate routine’.<sup>1652</sup> A separate routine was defined in the Ashley Youth Detention Centre Standard Operating Procedure as follows:

A young person may be placed on a Separate Routine where their behaviour presents a risk to others or to the security of the Centre but which can be managed without resort to isolation. It may involve restrictions on contact with other specific young people or certain programs and areas of the Centre. It may also entail closer supervision and/or restriction to a particular Unit. This strategy can be used to deal with risks such as threats of harm to self and others, threats of escape and subversive and inciting behaviour. A Separate Routine can only be approved by the [Centre Support Team] or [Interim Centre Support Team], must be reviewed at least twice a week and must be discontinued as soon as the level of risk permits.<sup>1653</sup>

The 10 November 2016 response to Mr Morrissey noted the terms ‘unit bound’, ‘separate routine’ and ‘individual program’ were often used interchangeably, and they had not ‘been considered a form of isolation as a Youth Worker is always present’. However, the response noted other jurisdictions had interpreted being separate from other children and young people in detention to be isolation.<sup>1654</sup> The Acting Deputy Secretary, Children and Youth Services noted:

At this stage Individual Programs provide [Ashley Youth Detention Centre] staff with the flexibility to manage quite challenging behaviours, safely, without resorting to isolation. As more work is done to increase the range of therapeutic responses available to staff, the need for Individual Programs delivered as a Separate Routine will be reviewed.<sup>1655</sup>

The Acting Deputy Secretary, Children and Youth Services further observed that, at that time, a revised policy regarding isolation was being prepared for the Centre, which would require a ‘significant amount of policy work’ to define ‘normal routine’, including ‘separate routine’ and ‘induction routine’.<sup>1656</sup> He invited the Commissioner for Children and Young People’s involvement in this process.

On 11 November 2016, Mr Morrissey wrote to the then Minister for Human Services, copying in Secretary Pervan. This letter addressed several issues, including the use of isolation at Ashley Youth Detention Centre and the Commissioner for Children and Young People’s ‘concerns about a lack of clarity around what isolation is and around the current legislative prohibition on its use as a punishment’.<sup>1657</sup>

Mr Morrissey noted that, at Ashley Youth Detention Centre:

... there may be a view that if a young person is locked up with a youth worker, then, regardless of anything else, that will in and of itself negate categorisation of treatment as isolation. I have indicated my disagreement with such an approach.<sup>1658</sup>

Mr Morrissey expressed the view that a practice should be considered isolation if a young person was separated *from other young people* and from the normal routine of the Centre.<sup>1659</sup> He supported this view by referring to the approach taken in Victoria, where legislation defined isolation in similar terms to the Youth Justice Act.

Mr Morrissey was similarly direct in expressing his concern about the Centre's 'resort to practices similar to if not identical to isolation but which are referred to by other terminology'.<sup>1660</sup> He noted the need to clarify different, seemingly interchangeable terms such as 'unit bound', which may amount to isolation where a young person was the sole occupant of the unit to which they were confined.<sup>1661</sup>

On 18 November 2016, Secretary Pervan responded to Mr Morrissey's concerns, copying in the Minister for Human Services.<sup>1662</sup> Secretary Pervan stated:

- procedures at the Centre relating to restrictive practices, including isolation, were under review
- the draft revised Isolation Procedure had 'a much greater focus on isolation as a prohibited action, except for in very specific circumstances'
- isolation should be a 'last resort'.<sup>1663</sup>

He indicated the use of isolation was, at least partially, a result of a lack of therapeutic responses:

As more work is done to increase the range of therapeutic responses available to staff it is expected that the use of isolation as a strategy to manage unsafe behaviours should reduce. To this end, staff have undertaken refresher training in Non Violent Crisis Intervention (NVCI) and are currently participating in Trauma Informed Care training.<sup>1664</sup>

Secretary Pervan's response also acknowledged Mr Morrissey's concerns regarding practices that are 'similar to isolation, but which are referred to by other terminology' and referred to the 'work' to define 'normal routine and separate from others', including potentially needing to make legislative changes.<sup>1665</sup> The response did not substantively address Mr Morrissey's concern that isolation may be used under a different name and with significantly fewer protections in place to prevent harm to young people in detention.

On 4 January 2017, Mr Morrissey again emailed the Acting Deputy Secretary, Children and Youth Services (copying in Secretary Pervan) seeking clarification regarding a complaint from a young person at the Centre about isolation practices.<sup>1666</sup>

Mr Morrissey stated it appeared the young person was, in effect, being held in isolation despite such isolation being alternatively defined as ‘unit bound’, and that this was causing ‘significant distress’:

I have been provided with a copy of [the young person’s] individual program and note that he is unit bound—he takes his meals in the Unit, does not participate in the normal routine of the Centre and does not mix with any of the other boys. He is the sole resident of his Unit ...

If [the young person] is being kept separate from the normal routine and from the other detainees, please advise how this does not amount to ‘isolation’ as defined in the new Procedure governing Isolation ...<sup>1667</sup>

The Acting Deputy Secretary, Children and Youth Services responded later the same day.<sup>1668</sup> Beyond providing details of the individual young person’s circumstances (the young person had rejoined regular programs at the Centre that day), he disagreed the circumstances constituted isolation but did not elaborate on why.<sup>1669</sup> The Acting Deputy Secretary did note the ‘individual program’ standard operating procedures and arrangements would need to be reviewed.<sup>1670</sup>

On 11 January 2017, Mr Morrissey again emphasised in an email to the Acting Deputy Secretary, Children and Youth Services that, in his view, these practices constituted isolation:

I believe that what is occurring is actually isolation, based on the content of the revised SOPs [Standard Operating Procedures]. My reason for saying this is that [the young person] was also on his own—essentially unit bound, separate from other detainees—and on individual program. The old SOP dealing with isolation referred to ‘separate routine’—which appears to be how [the young person] was treated.<sup>1671</sup>

On 19 January 2017, Mr Morrissey sent another email to the Acting Deputy Secretary, Children and Youth Services regarding the same young person. It appears this young person was again being held separately from other young people at the Centre and was ‘very upset and escalating’.<sup>1672</sup> Mr Morrissey noted he had raised ‘on a number of other occasions’ that isolation is ‘highly counterproductive to a therapeutic approach’ and ‘often will directly contribute to escalating distress and behaviour issues’.<sup>1673</sup> His frustration at the continued practice of isolating this young person, seemingly in preference to alternative therapeutic options for de-escalating and managing behaviour, was evident from his correspondence.<sup>1674</sup>

## 6.1 Our observations

It is our conclusion that, during 2016 and early 2017, the Department and the Tasmanian Government were again made aware and put on notice of routine isolation practices that potentially contravened Tasmanian law and human rights principles to which Australia was a signatory. The Department had internally acknowledged the veracity of these concerns through the 2016 Minute, which appeared to us to be an urgent call to action from the Deputy Secretary, Children and Youth Services and the Director at the time to address routine human rights abuses the Centre.

We were deeply troubled that, despite the 2016 Minute's internal recognition that unlawful isolation practices were likely occurring, we saw no evidence of action taken to remedy the ongoing human rights abuses being perpetrated against the young person for whom Mr Morrissey had repeatedly advocated. The Department failed to act in the best interests of this young person and any other children subjected to potentially unlawful isolation practices during this period.

We note some in the Department appeared to take the view that the reference to 'separate from others' in relation to isolation under the Youth Justice Act meant that a young person in detention would not be in isolation if a youth worker was present. We share Mr Morrissey's view that 'separate from others' should be taken to mean separate from other young people in detention, particularly given that Victoria adopted this approach in relation to the same phrasing in its legislation.

We note that this view by the Department had resonances with its 30 July 2013 response to Deputy Chief Magistrate Daly, which appeared to focus closely on the term 'routine' in the definition of isolation. It appeared to suggest that because the Blue Program was part of the Behaviour Development System, which was part of the 'routine' of the Centre, a young person in detention under the Blue Program was not in isolation.

We note how the Youth Justice Act is interpreted and applied remains relevant given that the Tasmanian (and Victorian) legislative definitions of 'isolation' continue to refer to locking a young person in detention in a room separate *from others* and from the normal *routine* of the Centre. We consider a plain language description of the daily experience of a child or young person on the Blue Program or who is unit bound would help determine whether a child is in isolation under the Youth Justice Act.

## 7 Continuing concerns in 2017

On 19 February 2017, Mr Morrissey wrote to the Custodial Inspector, Richard Connock, requesting his opinion on whether the practices that Mr Morrissey had been discussing with departmental officials for several months amounted to isolation.<sup>1675</sup> Mr Morrissey observed to Mr Connock that ‘the interpretation of what constitutes isolation remains an irresolute issue’.<sup>1676</sup>

On 2 June 2017, Mr Morrissey wrote to Ginna Webster, who was Deputy Secretary, Children and Youth Services at the time, again raising the issue of isolation and concerns over the use of definitions. He noted no progress appeared to have been made since January 2017:

My primary concern relates to the use of separate routine for the young people. I have formed a general view that it is indeed likely to be isolation. Separate routines at times extend for considerable periods. A therapeutic strategy for these young people may be able to offer less isolating options.<sup>1677</sup>

At that time, Mr Morrissey also noted he had not received a reply from Mr Connock in response to his request for an opinion in February.<sup>1678</sup> Mr Morrissey told us he left the role of Commissioner for Children and Young People in October 2017, after deciding the momentum for influencing reforms in the role had stalled, and that it was time for a change.<sup>1679</sup> In Chapter 18, we discuss Mr Morrissey’s belief that on a number of occasions the independence of his role was undermined. It is unclear if Mr Connock ever provided a formal response or opinion on the issue to Mr Morrissey. While Mr Connock recalls being in regular contact with Mr Morrissey at around this time, he told us he had no recollection of the email.<sup>1680</sup> We are pleased to note that on 1 July 2017, a new Isolation Procedure was introduced by Ms Webster, as delegate of the Secretary of the Department, under section 124(2) of the Youth Justice Act.<sup>1681</sup> This is the procedure outlined in Section 2 and it clearly identifies that isolation should be used as a last resort and as a short-term tool to address immediate safety or security concerns. In the following section, we note ongoing concerns about formal isolation practices under this procedure. In Chapter 12, we identify further improvements to the Isolation Procedure.

## 8 Reviews of unit bound and similar practices in 2018 and 2019

A subsequent report by Mr Connock, titled *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* was published in August 2019.<sup>1682</sup>

The inspection of Ashley Youth Detention Centre for this report occurred in February 2018, seven months after the introduction of the new Isolation Procedure.<sup>1683</sup> In the report, Mr Connock considered the isolation practices that engaged the Centre's official Isolation Procedure.<sup>1684</sup> Mr Connock identified serious failures regarding the use of official isolation, including the failure to:

- regularly review and monitor instances of isolation
- meet minimum observation requirements while young people are held in isolation
- keep proper records regarding young people being held in isolation, including:
  - it appeared staff were copying and pasting different incident reports
  - documentation intended to explain or justify the use of isolation was incomplete.<sup>1685</sup>

The report did not discuss other isolation practices, such as unit bound practices or segregation, being used at the Centre outside the formal isolation safeguards.

### 8.1 Our observations

We conclude the Department and the Tasmanian Government were made aware in 2019 that, despite implementing a new policy and staff training in response to issues raised over the previous six or more years, formal isolation practices at the Centre continued to raise concerns for oversight bodies.

## 9 The reintroduction of the Blue Program in March 2019

### 9.1 The decision to reintroduce the Blue Program

On the evening of 7 March 2019, staff of Ashley Youth Detention Centre were notified by email from Patrick Ryan, Centre Manager at the time, that the Blue Program was being reintroduced for three months, at which point a decision on its continued use would be made.<sup>1686</sup> Greg Brown, then Director, Strategic Youth Services in the Department, was forwarded this email soon afterwards.<sup>1687</sup> Mr Brown was in this role between December 2017 and October 2019. Reference to the Blue Program in this section refers, unless noted otherwise, to the form of the program that was reintroduced in 2019.

The details of the Blue Program were set out in a series of documents Mr Ryan distributed to staff.<sup>1688</sup> In these documents, the Blue Program was described as a program to be used where a ‘young person **persistently** breaks the rules of the Centre and is at risk to themselves or others’ [emphasis in original].<sup>1689</sup>

Examples of situations that may attract a blue colour code were identified as attempts to escape, violent or assaultive behaviour, possession of a weapon and other behaviours that are ‘disruptive to the order of their Unit or the Centre broadly’.<sup>1690</sup>

The relevant policy documentation stated:

Whilst on Blue colour, which puts them outside normal Centre routine, the young person must be able to participate in an intensive support program that permits them to continue with their education, work, recreation or therapeutic activities until they are able to participate effectively in normal programming and normal Centre routine ...

Being placed on Blue colour is **not** the isolation of a young person, but a management tool used to manage the behaviours of individuals who consistently refuse to adhere to the rules and good order of the Centre or are unable to assimilate with the broader [Ashley Youth Detention Centre] community [emphasis in original].<sup>1691</sup>

The documentation also listed the following key practice under the program:

A young person is fully segregated from Ashley School, daily programs and activities, other young people in their Unit (subject to risk assessment) and the normal routine of the Centre.<sup>1692</sup>

The process for placing a young person on the Blue Program involved initial consideration by the Centre Support Team or Interim Centre Support Team (an ad hoc meeting of the Centre Support Team), followed by Mr Ryan or his delegate ratifying the decision.<sup>1693</sup> The Centre Support Team or Interim Centre Support Team would then decide the ‘nature of the intensive support program’ for the young person while on the Blue Program, including the extent of any restrictions on the movement of that young person.<sup>1694</sup> A young person’s eligibility to take part in Centre activities and programs in their unit was subject to a risk assessment.<sup>1695</sup>

Communications to staff and young people at the Centre emphasised the Blue Program was not a ‘punishment option for difficult behaviour but rather an opportunity to maintain safety and security, as well as allowing the young person time to settle and be re-integrated back into normal routine’.<sup>1696</sup>

Mr Ryan confirmed to us that when young people on the Blue Program were in their room, their door was locked and there was no other person in the room with them.<sup>1697</sup> However, he disagreed the Blue Program was isolation of the kind prohibited by the Youth Justice Act.<sup>1698</sup> Instead, he stated it was ‘working under a program’ and that the program was part of ‘normal routine’, accordingly bringing it in line with the Centre’s Isolation Procedure and the requirements of the Youth Justice Act.<sup>1699</sup>



Mr Ryan's evidence was that the reintroduction of the Blue Program followed two significant events of property damage at Ashley Youth Detention Centre. The first occurred on 25–26 February 2019 and the second on 6–7 March 2019.<sup>1700</sup> Mr Ryan explained these incidents had 'raised serious concerns for the wellbeing of the residents as well as staff'.<sup>1701</sup> Mr Ryan told us, 'immediate steps needed to be taken to better deal with serious incidents' and described the reintroduction of the Blue Program as a temporary 'circuit breaker' in response.<sup>1702</sup>

We were provided with various Centre Support Team meeting minutes for the period following the reintroduction of the Blue Program. Those minutes indicate that children sometimes remained on the Blue Program for long periods. For example, the minutes of 12 March 2019 show that on that date, three young people were on the Blue Program.<sup>1703</sup> Minutes of Centre Support Team meetings held over the following two weeks show that one of those young people remained on the Blue Program up to at least 25 March 2019 (at least 18 days).<sup>1704</sup> Another of those young people remained on the Blue Program until at least 1 April 2019 (at least 25 days), at which point he was moved to the red colour level and placed on unit bound.<sup>1705</sup> Over this period, Mr Ryan provided Mr Brown with email updates detailing the number of young people on the Blue Program, and providing their names, where relevant.<sup>1706</sup>

Mr Brown told us in his statement that he did not recall when he was briefed about the Blue Program, but he noted Mr Ryan 'would have briefed me verbally through phone calls or at meetings and followed up with emails or even an Issues Brief'.<sup>1707</sup>

Regarding the reintroduction of the Blue Program, Mr Brown said:

From memory it was reintroduced by the Manager [Ashley Youth Detention Centre] as a result of an incident involving a number of residents but I cannot recall any specific details. I do not recall whether I had any involvement in its reintroduction outside of being briefed by the Manager and me then briefing the Deputy Secretary and/or Secretary. If I had a role in its operation or implementation it would have only been a decision-making delegation, but I do not recall any.<sup>1708</sup>

Mr Brown told us he did 'not recall having any concerns about the use of isolation/unit bound/blue program'.<sup>1709</sup>

### **9.1.1 Our observations about the reintroduction of the Blue Program**

It is our view that, in March and April 2019, the Department was aware, or should have been aware, that a behaviour management approach had been reintroduced. A magistrate, a Commissioner for Children and Young People, and a 2016 departmental Minute to the Secretary had previously identified this approach as a likely human rights violation amounting to unlawful isolation. As outlined in the following section, the new Commissioner for Children and Young People was raising concerns about isolation practices prior to and while the Blue Program was being reintroduced.

While the Department confirmed it was aware of the reintroduction of the Blue Program in 2019, Secretary Pervan told us he does not recall being notified of matters concerning the reintroduction of the Blue Program in or around 2019. He said he only became aware of these matters through our Commission of Inquiry.<sup>1710</sup>

We consider that, despite reassurances that the Blue Program was not to be used as punishment, the excessive time children and young people were unit bound (18 or 25 days) may have reasonably felt like punishment to those young people.

## 9.2 Concerns raised by the Commissioner for Children and Young People in 2019

The reintroduction of the Blue Program involved, in part, what appears to be a concerning chain of correspondence between the Centre’s management and Leanne McLean, Commissioner for Children and Young People, following her appointment to that role in November 2018. The relevant aspects of that correspondence are described below.

On 4 March 2019, before the 6–7 March 2019 incident, Commissioner McLean wrote to Mr Ryan and Mr Brown stating that several young people at Ashley Youth Detention Centre were unit bound. Commissioner McLean requested a copy of the policy or procedure that guided the decision to place the children on unit bound.<sup>1711</sup> Mr Ryan responded (copying in Mr Brown), requesting a few days to collate the information.<sup>1712</sup>

On 7 March 2019 at 5.57 pm, Mr Ryan notified staff at the Centre that the Blue Program had been reintroduced temporarily.<sup>1713</sup> Approximately 30 minutes later, at 6.26 pm, Mr Ryan responded to Commissioner McLean’s request for information, noting:

- the unit bound activities she had identified formed part of the response to the 25–26 February 2019 incident
- the Behaviour Development System had previously recorded unit bound practice ‘within the Blue Program’ and the Blue Program was reintroduced in a temporary capacity
- Mr Ryan would provide a copy of the revised Behaviour Development System the next day.<sup>1714</sup>

On 7 March 2019, at 6.35 pm, Mr Ryan instructed the then Assistant Manager of Ashley Youth Detention Centre, Piers (a pseudonym), to ‘amend the [Behaviour Development System] with the stuff I sent in the other email’, stating that once that was complete, Mr Ryan would forward a copy of the Behaviour Development System to Commissioner McLean.<sup>1715</sup>

We note that Mr Ryan’s response to Commissioner McLean gave the impression the Blue Program had been temporarily reintroduced in response to the 25–26 February incident. However, we question the accuracy of this for two reasons:

- Mr Ryan only emailed staff on 7 March 2019 that the Blue Program had been reintroduced temporarily, which was days after the 25–26 February 2019 incident and after Commissioner McLean’s email.
- Mr Ryan instructed Piers to ‘amend’ the Behaviour Development System on 7 March 2019 before its release to Commissioner McLean.

When this inconsistency was put to Mr Ryan during our public hearings, he did not accept the correspondence suggested that he was implementing a program that was not otherwise reflected in the Behaviour Development System at the time.<sup>1716</sup> Instead, he stated his instructions to Piers merely reflected his desire to ensure the version of the Behaviour Development System provided to Commissioner McLean was current.<sup>1717</sup> He explained this was because there were ‘a number of different copies’ of the Behaviour Development System at the Centre at the time.<sup>1718</sup>

Mr Brown was copied into the email correspondence between Mr Ryan and Commissioner McLean.<sup>1719</sup> We are not aware of any separate response made by Mr Brown to that correspondence.

At best, this explanation during our hearings indicates a dysfunctional record and policy management system at the Centre, where the applicable policy was difficult to determine or locate. Such poor record keeping creates a risk of the incorrect or inconsistent application of the Centre’s policies, many of which give operational effect to important legislative obligations.

At worst, the correspondence with Commissioner McLean suggests an attempt to mislead her as to the formal status and use of the Blue Program and the authorisation for placing children and young people on ‘unit bound’.

Mr Ryan gave evidence that the reintroduction of the Blue Program followed ‘consideration through consultation and meetings’, including with the Centre Support Team and the Multi-Disciplinary Team at the Centre.<sup>1720</sup>

Given the timeframes involved, it is difficult to conclude the program was given thorough consideration before its reintroduction. Centre staff had, at most, approximately one week following the end of the first incident referred to by Mr Ryan (25–26 February 2019) to consider the appropriateness of the Blue Program. Further, Mr Ryan suggested the 6–7 March 2019 incident also contributed to the decision to reintroduce the program. If so, it appears the decision was reached only a matter of hours following the conclusion of that incident, as Mr Ryan’s directive on the Blue Program was issued on the evening of 7 March 2019.

Ms Gardiner, who jointly held the Professional Services and Policy Manager role with another staff member at Ashley Youth Detention Centre in March 2019, denied being formally consulted on the matter.<sup>1721</sup> She asserted that, instead, she learned about the

reintroduction of the Blue Program along with other staff when the email was sent to Ashley Youth Detention Centre staff on the evening of 7 March 2019.<sup>1722</sup> She considered any consultation with the Centre’s Professional Services Team about the reintroduction of the program was minimal, and she was not aware that any consultation occurred with other senior managers at the Centre.<sup>1723</sup>

We have considered the Multi-Disciplinary Team and Centre Support Team meeting minutes available for the period 1 February 2019 to 10 March 2019. We have been unable to identify in those minutes any discussion of the reintroduction of the Blue Program. We also considered the draft meeting minutes of a Behaviour Development System Review Committee at the Centre, which met at least three times between November 2018 and February 2019.<sup>1724</sup> Draft minutes of a meeting that Committee held on 19 February 2019 noted attendees unanimously supported establishing a working group to consider whether the Behaviour Development System was ‘consistent with the [Ashley Youth Detention Centre] “therapeutic direction”’.<sup>1725</sup> Otherwise, there was no suggestion in minutes available to us that this Behaviour Development System Review Committee was asked to consider or consult on the reintroduction of the Blue Program.

We received evidence that the other Manager, Professional Services and Policy, Digby (a pseudonym) (who held that role jointly with Ms Gardiner) was the person responsible for the Behaviour Development System and was involved in preparing the relevant Blue Program documentation.<sup>1726</sup> Digby had made Mr Ryan aware of the Blue Program’s problematic history.

In an email to Mr Ryan dated 7 March 2019, Digby stated:

Just briefly the Blue Colour Category was first introduced in early 2011 to cater for the deep Red residents who had to be managed intensively for a period of time. It was rescinded in December 2013 (although fondly remembered by some staff) because it had become more broadly used (for some residents who didn’t really need it) and was considered in some quarters to be a punishment option.<sup>1727</sup>

In April 2019, Mr Ryan prepared a draft Issues Briefing to the Minister updating the Minister on matters relating to the February and March incidents.<sup>1728</sup> That draft Issues Briefing noted:

The [Ashley Youth Detention Centre] Behaviour Development System was amended to reintroduce the Blue Program as an interim measure for three months. The program is an individual intensive support program and affords some segregation from other residents. It was reintroduced after the second incident and was considered through the Centre Support Team (CST) meeting following.<sup>1729</sup>

This briefing and Mr Ryan’s response to the Commissioner for Children and Young People appear inconsistent. The Issues Briefing suggests the Blue Program was reintroduced after the 7 March 2019 incident, whereas Mr Ryan’s response to the Commissioner suggests the Blue Program was introduced in response to the 25–26

February 2019 incident. Mr Ryan disagreed the documents were inconsistent and told us the Blue Program was only reintroduced after the 7 March 2019 incident.<sup>1730</sup>

We were not provided with a final version of this Issues Briefing. It is unclear to us what information was provided to the Deputy Secretary, Secretary or Minister about the reintroduction and operation of the Blue Program.

This was the second Commissioner for Children and Young People and the third external party to raise concerns about the Blue Program with the Department, in addition to the Custodial Inspector's concerns about formal isolation practices.

### 9.3 Attempts to reform the 2019 Blue Program

We understand concerns were raised within the Centre about the Blue Program at the time of its reintroduction in 2019. Ms Gardiner's evidence was that she and other members of her team considered the Blue Program to be lacking any therapeutic benefit.<sup>1731</sup> Ms Gardiner told us she:

... considered the [Blue Program] highly unsuitable for a young person who was displaying highly aggressive/violent and dysregulated behaviour. Whilst in the short term the security and safety risk of the Centre needed to be addressed, the content and delivery of the program was not trauma informed, developmentally appropriate or designed to meet the needs of the cohort of young people in the Centre.<sup>1732</sup>

She noted her concern the Blue Program interfered with the rights of young people to educational opportunities secured under the Youth Justice Act and international standards.<sup>1733</sup>

On 16 March 2019, Ms Gardiner emailed Mr Ryan with suggestions 'to improve the program to provide support to young people to [meet] their developmental and trauma needs'.<sup>1734</sup> Those suggestions included:

- reviewing the content of the individual programs from a literacy perspective, to ensure they could be understood appropriately by young people (noting the generally low literacy among young people at the Centre)
- reducing the 'cognitive heavy' content of the programs, which Ms Gardiner considered unhelpful in a context where young people were on the program because of assaultive or threatening behaviour, suggesting a level of distress
- adopting adjunct programs that address trauma and complement trauma-informed practices, such as programs that can 'calm the brainstem and limbic system'
- consulting with the Health Team at the Centre and the Australian Childhood Foundation for help in program development
- ensuring youth workers were appropriately skilled and trained to deliver the content of the individual programs.<sup>1735</sup>

Ms Gardiner recalled Mr Ryan’s initial reaction to her suggestions as ‘being open to improvement’.<sup>1736</sup> Mr Ryan responded to Ms Gardiner’s email positively, stating he saw her role as ‘guiding residents and staff’.<sup>1737</sup> He noted, however, there would ‘need to be some “selling” of [Ms Gardiner’s suggestions] to staff’.<sup>1738</sup>

Ms Gardiner described how her Professional Services Team then developed a series of measures to improve the Blue Program content and delivery, based on trauma-informed practice and attachment theory, and building on the work of the Australian Childhood Foundation.<sup>1739</sup> She said her team worked ‘a bit on the run’, given the program had already been put in place.<sup>1740</sup> She recalled that, on a daily basis, her team would develop individual programs for each of the young people on the Blue Program, which involved roughly hourly alternations between therapeutic program content, such as psychological support or education, and ‘calming regulation activities’, such as using the gym one-on-one with a youth worker or more meditative activities, such as puzzles.<sup>1741</sup>

Ms Gardiner considered the modified Blue Program, as developed by her and her team, was positive in the sense that it appeared to work by bringing children quickly off the program and back into the Centre’s general activities. However, she did not have sufficient time to evaluate its success.<sup>1742</sup>

Ms Gardiner conceded the version of the Blue Program as modified by her team still involved a degree of isolation, where children might be left alone every second hour or so (in between therapeutic program delivery). However, she considered, on balance, that young people had more contact with others than on the original planned 2019 Blue Program.<sup>1743</sup>

We were interested to hear Mr Ryan’s view that he thought Ms Gardiner considered the reintroduction of the Blue Program ‘was the best thing that could have happened in the circumstances ...’.<sup>1744</sup> Based on the evidence available, it is difficult to reach a conclusion that Ms Gardiner supported the reintroduction of the Blue Program; rather, she appears to have worked to improve the Blue Program once it was in use.

At this time, even with the improvements Ms Gardiner implemented, the evidence available to us showed the Blue Program often (if not always):

- segregated children from other children and young people in detention
- denied children and young people the right to take part in the usual educational programming offered through Ashley School
- involved children and young people being locked in their rooms for hours at a time
- sent children and young people to bed at an excessively early time for an adolescent
- locked children and young people in their room from this early time until the morning.



It remains unclear to us what, if any, opportunities children and young people had to take part in activities with other young people in their unit. However, we consider it likely they were segregated from other children and young people all or most of the time.

## 9.4 Departmental correspondence about the Blue Program

We were given a draft email from Mr Brown dated 21 May 2019 intended for Ginna Webster—who, at that time, had become the Secretary of the Department—that refers to the ‘Blue Program’, ‘unit bound’, ‘reflection activities’ and ‘individualised programs’, but not isolation:

In March the Blue Program was reintroduced in response to two major incidents at [Ashley Youth Detention Centre] and following the incidents the Centre was unsettled. Three residents were put on Blue after the major incidents.

The ‘old’ Blue Program (developed over 20 years ago) had the resident unit bound and used some reflection activities. Whilst it contained [an] excellent sense of security and structure for residents and staff, some of the theories it was developed from have been superseded by more contemporary theory and it does need to have a thorough review to ensure it aligns with a therapeutic model of care.

With its reintroduction, it was quickly identified that the reflection activities were not supporting the residents to progress i.e. ‘move up colours’ on the Behaviour Development System (BDS) used by the Centre. As a result, elements of the program were changed and an active support program was introduced. This became a daily schedule for Blue residents in the unit, with daily psychology, case management and education programs, as well as scheduled exercise and gym sessions. This resulted in two of the Blue residents progressing up the colours at the next week, and progress was much improved. The Professional Services and Policy (PS&P) staff developed daily individualised program timetables and documents to support the Blue Program, so it was an increased support program.

Due to complex presentations and behaviour by the Blue residents, [the Centre] initiated a [Senior Quality Practice Advisor] referral for further advice regarding the Blue program to ensure [the Centre] was considering all available therapeutic options for the residents on Blue, however the referral was declined by [Quality Improvement and Workforce Development]. Notwithstanding this, a review of the reintroduction of the Blue Program is to be undertaken in the near future. The review will consider how the program aligns to therapeutic care, and supports young people who are displaying highly dis-regulated behaviour, as occurred in the recent major incidents.<sup>1745</sup>

We are concerned this correspondence—and specifically the reference to the young people ‘progressing up the colours at the next week’—suggests that they were on the Blue Program or unit bound for days.<sup>1746</sup>



Secretary Webster told us she did not recall receiving this email, although she accepted it was possible she did. She also noted that nothing in the email indicates that the Blue Program was correlated to a form of isolation.<sup>1747</sup>

## 9.5 Further concerns raised by the Commissioner for Children and Young People in 2019

We received evidence of a further attempt by Commissioner McLean, in late 2019, to clarify the nature of isolation practices at Ashley Youth Detention Centre.

On 22 August 2019, Commissioner McLean wrote to Secretary Webster seeking clarification about the difference between unit bound and formal isolation, and how a decision about placing a young person on unit bound was reached.<sup>1748</sup>

Commissioner McLean raised the following concerns:

- The Behaviour Development System did not clarify when and how a decision was made for a young person to be unit bound.<sup>1749</sup>
- The colour allocated to a young person did not appear to necessarily result in a young person being unit bound, ‘suggesting that a decision to confine a young person to their unit is not solely covered by the [Behaviour Development System]’.<sup>1750</sup>
- It was unclear whether it was mandatory for a young person who was unit bound to be provided with an individual program.<sup>1751</sup>

Commissioner McLean requested a copy of the policy or procedure governing decisions to confine a young person to their unit, and the criteria relevant to such a decision, as well as clarification of the difference between isolation and unit bound.<sup>1752</sup>

Commissioner McLean’s request was forwarded to Mr Brown, who then asked that Mr Ryan and Ms Gardiner prepare a draft response and associated Issues Briefings.<sup>1753</sup> On 4 September 2019, Mr Ryan emailed a staff member at the Centre a draft Issues Briefing to the Secretary regarding Commissioner McLean’s request, for forwarding to Mr Brown.<sup>1754</sup> The draft Issues Briefing to the Secretary contained the following observations:

- Young people on unit bound were ‘from time to time confined to their unit ... as a result of the governing Behaviour Development System’ used at Ashley Youth Detention Centre.<sup>1755</sup>
- Commissioner McLean’s statement that it appeared a decision to place a young person on unit bound was ‘not solely covered’ by the Behaviour Development System was partially correct.<sup>1756</sup> Mr Ryan explained that ‘there is an element of discretionary decision making for resident movement’ and that the colour rating

held by a young person ‘can determine an activity the resident may or may not participate in, ratified at Centre Support Team meetings’.<sup>1757</sup>

- Regarding individual programs, Mr Ryan explained the Program Assessment Team terms of reference, ‘holds a strong premise and rationale of addressing programs for young people diversely and/or individually’.<sup>1758</sup>
- Mr Ryan confirmed there was ‘not one policy or procedure that governs decision making processes’ at Ashley Youth Detention Centre.<sup>1759</sup> Instead, the Behaviour Development System provided direction complemented by Centre Support Team, Multi-Disciplinary Team and Program Assessment Team processes.<sup>1760</sup>

Regarding the difference between isolation and unit bound, Mr Ryan explained in the draft Issues Briefing:

As previously mentioned, being ‘unit bound’ refers to residents who are from time to time confined to their unit as a result of the governing Behaviour Development System (BDS) and related procedures used at [the Centre]. Each of these are underpinned by [the Centre] striving to provide a safe and secure environment for young people in detention. ‘Isolation’ is described in the *Use of Isolation Procedure* and the *Youth Justice Act 1997* as ‘locking a detainee in a room separate from others and from the normal routine of the Centre’. Being ‘unit bound’ is within the normal routine of the Centre, in that it is programming and/or an Individual Timetable for a resident. The resident is not locked in a room within the unit, nor kept from other residents. ‘Unit bound’ is generally reserved against the Programmed day of 9 am to 4.30 pm, and outside opportunities of exercise and visits are always availed.<sup>1761</sup>

In his email to the staff member, Mr Ryan commented: ‘[o]n reflection, I’m happy that there is no prescription for “unit bound”. It’s good, tactical work across many areas of the Centre when we do “unit bound” a resident’.<sup>1762</sup>

At this time, Mr Ryan also prepared a draft Issues Briefing to the Minister and a draft response to Commissioner McLean.<sup>1763</sup>

The final Issues Briefing to the Minister, prepared by Mr Ryan, reviewed by Mr Brown and cleared by Secretary Pervan broadly reflected the matters Mr Ryan raised in the Issues Briefing to the Secretary.<sup>1764</sup> Secretary Pervan was newly appointed to Secretary of the Department at this time, having ceased responsibility for youth justice for a brief period from 9 May 2018 to 2 September 2019 because of a restructure.

In Secretary Pervan’s response to Commissioner McLean on 11 September 2019, he stated no unit bound procedure was in place.<sup>1765</sup> He explained to Commissioner McLean:

There is no separate Unit Bound Procedure in use at [the Centre]. The term refers to residents who are from time to time confined to their residential unit as a result of the governing Behaviour Development System (BDS) and related procedures used at [the Centre]. Each of these are underpinned by [the Centre] striving to provide a safe and secure environment for young people in detention.

In any detention centre, there is an element of discretionary decision making for resident movement. The [Behaviour Development System] affords a colour status to a resident, which can determine an activity the resident may or may not participate in, ratified at Centre Support Team meetings. Work Health and Safety Risk Assessments complement the decision-making process. Multi-Disciplinary Team and Program Assessment Team meetings also complement and aid the decision-making process.<sup>1766</sup>

Secretary Pervan also offered the following distinction between unit bound and isolation to Commissioner McLean:

‘Isolation’ is described in the Use of Isolation Procedure and the Youth Justice Act 1997 as ‘locking a detainee in a room separate from others and from the normal routine of the Centre’. Being ‘unit bound’ is within the normal routine of the Centre, in that it is specific programming and/or an Individual Timetable for a resident. The resident is not locked in a room within the unit, nor kept from other residents. ‘Unit bound’ is generally reserved against the programmed day of 9 am to 4.30 pm, and outside opportunities of exercise and visits are always availed.<sup>1767</sup>

Mr Brown is identified as the departmental contact in the Secretary’s letter to Commissioner McLean and was copied into the correspondence.<sup>1768</sup> We understand Commissioner McLean raised concerns about unit bound with Centre management at least once more.<sup>1769</sup>

## 9.6 Our observations

We observe that Commissioner McLean was the second Commissioner for Children and Young People to find it necessary to make persistent requests for clarification about the Blue Program and the practice of making young people in the Centre unit bound, and to question whether this amounted to isolation.

In our view, all formal correspondence regarding the Blue Program lacked a plain language description of the daily experience of children and young people in detention who were on the Blue Program, and the number of hours on average they were confined to their room or unit and segregated from other young people in the Centre. Clarity regarding these matters is material to Commissioner McLean’s concern about whether the Blue Program was a form of isolation.

We are also very concerned that the Blue Program was reintroduced despite prior internal and external conclusions that the Blue Program did amount to a form of isolation. There was a missed opportunity in the Department to scrutinise why the Blue Program had previously ceased before accepting its reintroduction. This missed opportunity meant a further cohort of children and young people detained at the Centre were subjected to the isolation practices inherent in the Blue Program.

Finally, we assume that Commissioner McLean (like Mr Morrissey before her) was asking questions and raising concerns about the Blue Program because of her engagement with children and young people detained at the Centre. There is no evidence in any departmental documentation provided to our Commission of Inquiry that children and young people detained at the Centre were ever given an opportunity to provide their experience of the Blue Program.

Failing to consider the benefits of engaging with and hearing the voice of children and young people about the Blue Program, particularly following the clarifications the Commissioner for Children and Young People requested, was a further missed opportunity by the Department that may have helped to identify the isolating features of the Blue Program and their impacts on children and young people more clearly.

We conclude that, because of these missed opportunities, isolation practices that were potentially outside the standards set by law, policy and international conventions continued at Ashley Youth Detention Centre for significant periods throughout 2019.

## 10 Roof incident December 2019

In December 2019, several young people in detention gained access to the roof of buildings at Ashley Youth Detention Centre. In this section, we consider this incident and the Centre's response of placing the children in isolation or related practices. We discuss allegations that isolation records were falsified after these young people were isolated. While the handling of this matter raises multiple questions about many practices, including the use of restraints and incident management procedures, we focus here on the use of isolation. Our summary of events relies heavily on a subsequent independent investigation of this matter.<sup>1770</sup>

We note the Centre's Isolation Procedure (effective 1 July 2017), discussed earlier, is relevant to how this incident was managed.<sup>1771</sup> At the time of the 2019 roof incident, the relevant instrument of delegation provided that the power to isolate a detained young person under section 133(2) of the Youth Justice Act (and therefore to extend the period of isolation), was delegated to the Centre's Operations Manager or the Director, Strategic Youth Services, only 'if the Detention Centre Manager is on leave, is uncontactable, or is unable for any other reason to perform the relevant function'.<sup>1772</sup>

### 10.1 The incident

Around noon on Friday 13 December 2019, three young people detained at Ashley Youth Detention Centre—Arlo, Elijah and Joseph (all pseudonyms)—accessed the roof of Ashley School, where they threatened staff with items dislodged from the roof.<sup>1773</sup> During the next approximately three hours, staff members at the Centre negotiated with Arlo, Elijah and Joseph to come down from the roof.<sup>1774</sup>

During this period, Ashley School and its offices were evacuated, and some young people were moved around the Centre while restrained with handcuffs.<sup>1775</sup> Mr Ryan, the Centre Manager, provided updates to Ms Honan, the Director, approximately every half hour.<sup>1776</sup> By this time, Ms Honan had assumed the role of Director from Mr Brown. Mr Ryan notified police of the incident but their attendance was not requested.<sup>1777</sup> Welfare checks were carried out for staff, and there was some evidence to suggest the same was done for young people not involved in the incident.<sup>1778</sup> Other young people were kept in their designated units, but routines and programs that could be carried out safely within each unit continued, as well as very limited access to the gym if available.<sup>1779</sup>

At approximately 4.00 pm, negotiations with Arlo, Elijah and Joseph were successful. They were escorted in handcuffs to a unit that had been emptied of other young people.<sup>1780</sup> Each had minor injuries to their feet or hands.<sup>1781</sup> No staff or other young people were injured.<sup>1782</sup> The Centre returned to normal operations and routine soon after.<sup>1783</sup>

## 10.2 The Centre's response: isolation and unit bound

Immediately following the incident, Arlo, Elijah and Joseph took showers and were given food.<sup>1784</sup> An Operations Coordinator, Chester (a pseudonym), authorised an initial period of isolation for Arlo, Elijah and Joseph, for approximately 30 minutes.<sup>1785</sup> The Acting Operations Manager, Maude (a pseudonym), extended the initial period of isolation by two-and-a-half hours.<sup>1786</sup> The three young people were then sent to bed (that is, continued to be locked in their rooms alone), consistent with the 7.30 pm bedtime for young people on the 'red' colour in the Behaviour Development System.<sup>1787</sup>

The immediate isolation after the incident was noted in an email to Ms Honan.<sup>1788</sup> Ms Honan also received a further email that the Operations Manager (whom we understand to have been Acting Operations Manager, Maude) was considering extending the initial 30-minute isolation period.<sup>1789</sup> Ms Honan was last substantively updated at 5.11 pm on 13 December 2019 by being copied into an email from Mr Ryan to Centre staff thanking them for their work.<sup>1790</sup> In that email, Mr Ryan stated that 'rehabilitation continues to occur after the incident, this evening and into next week'.<sup>1791</sup>

Before Mr Ryan left the Centre for the weekend, he spoke with Maude and Chester.<sup>1792</sup> In her evidence to the investigation of the incident, Maude stated she told Mr Ryan at this time that 'individual programs' would likely be used for Arlo, Elijah and Joseph over the weekend, and the Centre Support Team would review these programs on Monday 16 December 2019.<sup>1793</sup> Her evidence was that Mr Ryan gave no instructions about the use of isolation and instead, he said he would leave the issue to Maude and Chester to manage.<sup>1794</sup> In his evidence to the investigation of the incident, Chester shared Maude's recollection of these conversations.<sup>1795</sup>

On the morning of Saturday 14 December 2019, an acting Operations Coordinator and a youth worker at the Centre prepared ‘individual programs’ for each of the three young people involved in the incident.<sup>1796</sup> Arlo, Elijah and Joseph were placed on a rotating program of exercise, in-room activities and in-unit activities, separated from one another and from the other young people in detention.<sup>1797</sup> Their programs included multiple hours alone in their rooms each day, with intervals of being within their unit, and an option of one hour of exercise in the gym ‘if available’.<sup>1798</sup> The periods in their room ranged from one hour to three or four hours, with different activities offered.<sup>1799</sup> We understand the programs involved no contact with other children and young people.<sup>1800</sup> Professional Services Team members generally did not work on weekends and had no input into the individual programs.<sup>1801</sup>

The individual programs continued over the weekend until the morning of Monday 16 December 2019.<sup>1802</sup> Neither Mr Ryan nor the On-Call Manager were contacted over the weekend to authorise any periods of isolation.<sup>1803</sup>

Maude reported that, on the morning of Monday 16 December 2019:

... staff weren’t keen for the three residents to leave their unit until their attitude had shifted and staff were satisfied that they were going to follow appropriate direction and work with the staff and not against them. There was concern about them causing more damage. The three residents were unit bound at that time although they could access the unit common-room.<sup>1804</sup>

On the same morning, a Centre Support Team meeting was held, during which the individual programs for Arlo, Elijah and Joseph were discussed.<sup>1805</sup> The Program Coordinator at the time raised concerns about the individual programs during that meeting, later saying:

... [the individual programs were] in no way therapeutic or considered and it seemed to me that the young people involved had not had time outside and only very limited time out of their rooms; it was also clear that there were lengthy periods of isolation.<sup>1806</sup>

Notably, the minutes of that Centre Support Team meeting stated that ‘[f]rom observations over the weekend, it would appear that the boys have little remorse for their actions’.<sup>1807</sup>

Evidence provided to us indicates that Arlo, Elijah and Joseph each remained unit bound up to and including 24 December 2019 (at least 11 days).<sup>1808</sup> There is also evidence to suggest the three young people may have been offered time outside the unit occasionally during that period, possibly with a peer.<sup>1809</sup> While Interim Centre Support Team meeting minutes of 19 December 2019 suggest a decision was taken that day for Arlo, Elijah and Joseph to come off unit bound, this is inconsistent with the evidence of the daily rolls.<sup>1810</sup>



### 10.2.1 Our observations of isolation practices in December 2019

From our analysis, it appears that in December 2019, three young people at the Centre were subjected to isolation practices for at least 11 days that potentially did not comply with Tasmanian law or policy or international human rights standards. Again, we consider that irrespective of intent, being unit bound for this length of time may have reasonably felt like punishment to the young people involved.

## 10.3 December 2019 Issues Briefing

On Monday 16 December 2019, Mr Ryan prepared an Issues Briefing for the Minister about the roof incident. Between 16 and 20 December 2019, this briefing was passed through Ms Honan, Mandy Clarke (then Deputy Secretary, Children, Youth and Families) and Secretary Pervan, before being noted by the Minister on 7 January 2020.<sup>1811</sup> The Issues Briefing provided a summary of the events of 13 December 2019, noted injuries to each of Arlo, Elijah and Joseph, and provided estimates of the cost of damage to the Centre's property.<sup>1812</sup> The Issues Briefing commented that staff 'responded immediately and appropriately'—an assessment that could be considered premature, given the Issues Briefing stated a full review of the incident would follow.<sup>1813</sup>

The Issues Briefing did not disclose that the three young people had been isolated immediately following the incident or placed on individual programs, which, in our view, amounted to isolation, over the weekend following the incident.

We asked Secretary Pervan whether he considered the Issues Briefing sufficiently informed the Minister about the sanctions imposed on the three young people. Secretary Pervan responded that the sanctions were not 'central' to the Issues Briefing 'in the circumstances'.<sup>1814</sup> He said the content of an Issues Briefing was 'guided by the request' for the Issues Briefing, and there were regular opportunities for the Minister to ask any follow-up questions, including through 'daily dialogue' between the Department and Ministerial advisers and more formal regular meetings.<sup>1815</sup> Secretary Pervan did not confirm the Minister was advised at this time of the use of isolation, but stated he considered it 'highly unlikely' that the Minister was not made aware of these matters in the days following the event.<sup>1816</sup> We are unaware of any other correspondence or meeting minutes that might be evidence of an update to the Minister on these issues, or a request for such an update. We did not seek confirmation from the relevant Minister on this issue.

Ms Clarke gave evidence that she considered the Issues Briefing provided 'sufficient information in relation to the description of the actual event itself'.<sup>1817</sup> She thought the possible reason for the lack of information about how the young people were managed after the incident was a lack of knowledge about the matter among 'Department executives'.<sup>1818</sup>

We are unclear about the usual process for reporting isolation to the Department.



We know that Centre management made some reports to Ms Honan that identified isolation had been used in response to the 2019 roof incident. However, we are not aware the Centre Manager routinely reported all uses of isolation to the Director, as opposed to doing so only where it formed part of a response to a critical incident on site. Further, we are unaware of any notification by Centre management or Department staff to the Deputy Secretary or Secretary of the use of isolation or unit bound in response to this incident. We are concerned the evidence shows there was no requirement to formally report, in writing, all uses of isolation to senior Department officials.

We were advised by Ms Honan that the Issues Briefing included an overview of the incident that had occurred on the weekend based on immediate information available to Ms Honan at the time.<sup>1819</sup> Ms Honan said that when she cleared the briefing, ‘the information contained in it was correct and the immediate containment and management of the standoff, appeared compliant with the Restraint (Handcuffing) and Isolation policy and procedures’.<sup>1820</sup> Ms Honan also told us she was not consulted about any periods of isolation or the use of handcuffs in the management of the incident.<sup>1821</sup>

We understand it is normal practice for management at the Centre to perform an internal review following a significant incident, as had been foreshadowed in the above Issues Briefing. The review was incomplete as of 20 February 2020, when Secretary Pervan appointed an independent investigator to investigate the incident and associated response.<sup>1822</sup>

## 10.4 Concerns raised by staff about the incident

In late December 2019 and in January 2020, staff at the Centre raised concerns through multiple channels about the immediate response to the 2019 roof incident.

During this time, Ms Honan received communications from staff members who alleged that (among other things):

- isolation had been used without authorisation in response to the 2019 roof incident<sup>1823</sup>
- staff had been asked to backdate or sign isolation forms for practices that had occurred over the weekend in question<sup>1824</sup>
- operations staff had failed to appropriately consult with the Professional Services Team during the incident, placing the three young people involved in the incident at a high risk of harm.<sup>1825</sup>

Regarding the use of isolation without authorisation and the falsification or backdating of isolation records for the weekend of 14–15 December 2019, the allegations included:

- On Monday 16 December, Mr Ryan stated to the then Assistant Manager, Piers, that the isolation forms for the weekend were incomplete, and Mr Ryan directed Piers to ask the Operations Coordinators on shift that weekend to complete them.<sup>1826</sup>

- In the week beginning Monday 16 December, Piers began to pressure Maude to get other staff to sign isolation forms for 14–15 December.<sup>1827</sup> This included staff who had not been involved in the decision to isolate the young people.<sup>1828</sup> Maude reported to the independent investigation into the 2019 roof incident that those staff had declined to sign the forms because they thought the forms were forgeries, as isolation had not been appropriately authorised.<sup>1829</sup> Maude alleged that Piers told her ‘[y]ou’re just going to have to put on your steel-capped boots and get the staff to sign them’.<sup>1830</sup>
- Chester and a youth worker prepared some detail for the isolation forms, with reference to the individual programs that had been prepared.<sup>1831</sup>
- Chester eventually signed some isolation forms that had been prepared in the days following Monday 16 December, but told Maude he was uncomfortable about doing so.<sup>1832</sup>

In her statement to us, Ms Honan described her initial inquiries of staff about the post-incident management, particularly as it related to the completion of isolation paperwork. On 16 January 2020, as the internal review had not been completed, Ms Honan asked Mr Ryan to provide copies of the isolation forms, daily logs, individual programs and other notes prepared and produced in the period from 13 to 19 December 2019.<sup>1833</sup> She sought an independent investigation because of the seriousness of the concerns and the number of staff who would need to be interviewed to understand what had occurred.<sup>1834</sup> We discuss this independent investigation in the next section.

In addition, a psychologist working at Ashley Youth Detention Centre wrote to the Head of Department, Statewide Forensic Mental Health Services, Tasmanian Health Service (who was responsible for the Health Team at the Centre), raising the following concerns:

- Arlo, Elijah and Joseph had been out of their room for only approximately two-and-a-half hours a day on the Saturday and Sunday following the incident.<sup>1835</sup>
- Aside from verbal threats to a staff member who had not been on site since the incident, there appeared to be no reason to continue to isolate the young people, and that the apparent ‘lack of remorse’ on behalf of the young people seemed to motivate the decision to keep them isolated.<sup>1836</sup>
- Attempts by the psychologist to obtain information about isolation decisions in the days following the incident had been disregarded by Mr Ryan and Piers.<sup>1837</sup>
- Centre management had asked operations and professional services staff to backdate documentation, or sign documentation containing misleading and/or false information about the isolation decisions.<sup>1838</sup>

The former Head of Department, Statewide Forensic Mental Health Services, who received the psychologist's notification, told us she understood that the psychologist was interviewed by a representative of the Department of Communities in mid-January 2020.<sup>1839</sup> We understand the psychologist was told an investigation would follow.<sup>1840</sup> The psychologist's notification to the Tasmanian Health Service about this issue was one of many concerns the psychologist raised with their superiors at this time. We discuss other concerns that the psychologist held about the Centre's responses to harmful sexual behaviours in Case study 2.

## 10.5 The independent investigation of the incident

On 18 February 2020, Ms Clarke cleared a Minute to the Secretary requesting approval to appoint an investigator to investigate the December 2019 roof incident and associated post-incident management.<sup>1841</sup> The Minute identified a series of 'potential issues relating to the incident's management, both during and post the incident', including:

- the alleged use of physical force when moving young people around Ashley Youth Detention Centre, including the use of handcuffs<sup>1842</sup>
- concerns about the management of the response<sup>1843</sup>
- allegations that senior staff members directed operations and professional services staff to retrospectively sign documents authorising the isolation of Arlo, Elijah and Joseph, where no such authorisation had been sought<sup>1844</sup>
- the falsification of isolation records, including records of a young person's program activities and observations during periods of isolation.<sup>1845</sup>

The Minute noted the investigation may give rise to consideration of a subsequent breach of the State Service Code of Conduct investigation.<sup>1846</sup>

On 20 February 2020, Secretary Pervan approved the appointment of an independent investigator to investigate the incident and associated response.<sup>1847</sup> The scope of the investigation was to:

- prepare a chronology of the events during and immediately after the incident
- detail the management strategies for other young people at the Centre during the incident, including the methods used to move them around the Centre
- examine the involvement of operations and professional services staff throughout the incident and in the post-incident management
- identify procedures, legislative provisions and any other relevant directions or guidelines relevant to the incident, and to assess compliance with these in the identified period

- assess the effectiveness of the management response to the incident
- identify whether Arlo, Elijah and Joseph were subject to a period of unapproved isolation following the incident and, if so, to detail:
  - the processes used to implement and maintain that isolation
  - the decision-making and approval processes followed
  - the basis for that isolation
  - the programs provided to the young people during the period of isolation, and the involvement of operations and professional services staff in decisions relating to isolation
  - whether the period of isolation complied with the Centre’s policies and procedures, the legislative framework and any other relevant direction or guidelines
  - the preparation of documentation to support the isolation of young people.<sup>1848</sup>

While the investigator was not instructed to consider whether there had been a breach of the State Service Code of Conduct, the investigation appears to have been ordered with a view to consider whether there had been any behaviour that should be the subject of disciplinary action.<sup>1849</sup>

The investigator took statements or obtained answers to questions from Centre staff members significantly involved in the incident.<sup>1850</sup> The substantive report summarised the statements and attaches the full statements. Despite requesting them, we were not provided with the full statements.<sup>1851</sup> The investigator did not interview young people at the Centre.

The investigator’s final report is dated 26 March 2021 and addressed to Secretary Pervan.<sup>1852</sup> While the report did not contain formal recommendations, it noted a range of matters for the Secretary’s consideration.

Regarding the use of isolation, the independent investigator made the following observations:

- The initial 30-minute period of isolation was appropriately authorised by the Operations Coordinator in line with the Isolation Procedure and relevant delegation instrument.<sup>1853</sup>
- The extension of the initial period of isolation was likely to have been inconsistent with the Isolation Procedure and delegation instrument.<sup>1854</sup> The investigator considered that Maude had authorised the extension ‘in good faith’ but, in fact, she was only entitled to authorise the extension if Mr Ryan was on leave, uncontactable or unable to authorise it for some other reason.<sup>1855</sup> The investigator noted Mr Ryan’s view that he was ‘uncontactable’ if his ‘door was closed’ or he was ‘on the toilet’—a view the investigator disagreed with.<sup>1856</sup>

- Arlo, Elijah and Joseph were in fact isolated over the weekend, despite on-duty youth workers having a ‘misinformed/misguided’ view that no isolation was taking place and instead, the young people were simply on ‘individual programs’.<sup>1857</sup> Accordingly, isolation of the young people over the weekend occurred without appropriate authorisations under the Isolation Procedure.<sup>1858</sup>
- The evidence from Maude and Chester was that Mr Ryan was aware individual programs would likely be used to manage Arlo, Elijah and Joseph over the weekend and that Mr Ryan provided no instructions to staff about isolation.<sup>1859</sup> Mr Ryan contended that Operations Coordinators knew that approvals were required for the continuation of isolation.<sup>1860</sup>
- There was scope to conclude Centre management should have more actively ensured professional services staff were available out of hours to help prepare weekend programs for Arlo, Elijah and Joseph.<sup>1861</sup>
- Young people not otherwise involved in the incident had been confined to their units for the duration of the incident, with some suggestions they had been given access to in-unit programs where possible.<sup>1862</sup>

A key issue that emerged from the report regarding isolation was that several staff understood themselves to be carrying out the Blue Program, or a program that mirrored the Blue Program in form and substance.<sup>1863</sup>

Mr Ryan and Piers denied that Mr Ryan had instructed staff to use the Blue Program for Arlo, Elijah and Joseph over the weekend.<sup>1864</sup> However, the youth workers ‘had the Blue Program in mind’ when preparing the individual programs for Arlo, Elijah and Joseph.<sup>1865</sup> An Operations Coordinator who worked over the weekend said he understood the young people to effectively be on the Blue Program:

The [Centre] used to run a Blue Program for very bad behaviour with any resident involved being placed under isolation and doing lots of activities in their room with specifically prepared individualised programs. In January/February 2019 Patrick brought the Blue Program back in for a short period of time (or at least what was called an Individualised Program Routine) because of a particular event that had taken place that involved five residents in one standoff and about four or five others in another.

Over the weekend of 14 and 15 December I was under the impression that the Blue Program (or at least the Individualised Program Routine) that had been reintroduced by Patrick would apply. The terminology Blue Program wasn’t used; however, that is what I, and I believe the other staff involved over the weekend, thought was to occur with individualised programs for the three residents.<sup>1866</sup>

Statements received from staff members, and internal correspondence the investigator obtained, stated staff did not think isolation forms were needed because these had not been required in the past for the Blue Program.<sup>1867</sup>

Regarding the appropriate management of the young people over the weekend, the investigator invited Secretary Pervan to consider:

- whether Mr Ryan and Piers should have been more ‘actively’ involved in ensuring weekend programming for Arlo, Elijah and Joseph was appropriate, including whether Mr Ryan did enough to make sure that weekend staff understood that any use of isolation was to be in line with the Isolation Procedure<sup>1868</sup>
- whether relevant delegations concerning the Isolation Procedure were appropriately followed, including whether it was appropriate for Mr Ryan to contend that he was ‘uncontactable’<sup>1869</sup>
- whether it was reasonable to confine the young people not directly involved in the incident to their units, noting that the young people ‘would not seem to have been locked down (potentially meaning isolated) as that term is understood’<sup>1870</sup>
- the extent to which Professional Services Team members were now available after hours and over the weekend to assist with program management.<sup>1871</sup>

The investigator also suggested the Department perform a complete review of isolation routines at the Centre, specifically regarding how isolation periods were extended.<sup>1872</sup>

Regarding the concerns raised about the subsequent falsification or backdating of isolation documents, the investigator observed the following:

- It was a ‘significant issue’ that Chester signed the various isolation forms when he had acknowledged his view was that no isolation had occurred over the weekend.<sup>1873</sup>
- It was clear Chester and Maude had felt pressure to complete or backdate isolation forms because of Piers’ and Mr Ryan’s actions.<sup>1874</sup>
- Piers disagreed that Mr Ryan placed pressure on him to have the isolation forms completed.<sup>1875</sup>
- Piers acknowledged he had pressured Maude when he conceded he may have told her to ‘tough it up a little bit’.<sup>1876</sup>
- Mr Ryan and Piers had pressured Maude and, in turn, Chester to complete the isolation documentation.<sup>1877</sup>

The investigator noted Mr Ryan’s and Piers’ actions occurred in situations where they would likely have been aware the appropriate authorisations had not been sought. He said:

... it is difficult ... to understand why Ryan (through [Piers]), and [Piers] himself, pressed for the completion of [isolation documentation] when, on the balance of probabilities, both would have been aware that isolation was not conducted in accordance with [the Isolation Procedure] ...

It is also difficult ... to understand why [Maude] was pressured, and in turn pressed [Chester], to complete (backdated) isolation forms when on the balance of probabilities it was known by Ryan and [Piers] that isolation was not conducted in accordance with [the Isolation Procedure].<sup>1878</sup>

Regarding potential breaches of the State Service Code of Conduct, the report concluded:

In my view, you need to bring your mind to whether there were any breaches of the State Service Code of Conduct by Ryan, [Piers], [Maude] or [Chester] in the context of the completion of the isolation documentation [referenced in the body of the report].

In the context of the involvement of [Maude] and [Chester] in the completion of the related isolation documentation, in my view you should consider whether there are mitigating circumstances associated with the pressure that the evidence suggests to me was being applied by Ryan and [Piers]—more [Piers] but through Ryan in my assessment—to [Maude] and, in turn, [Chester] to have isolation documentation completed.<sup>1879</sup>

By the time the report was delivered, on 26 March 2021, Piers and Maude had been suspended from employment for reasons unrelated to the 2019 roof incident or the findings of the report, and Mr Ryan had left the Centre for an alternative role.<sup>1880</sup> Chester remained working at the Centre.<sup>1881</sup>

In summary, the report of the independent investigator, which was addressed to Secretary Pervan, raised concerns about the carrying out of isolation routines at the Centre, specifically in relation to how isolation periods were extended. It provided evidence the Blue Program was still believed to be used in practice, if not in name. It also raised serious questions about whether formal isolation procedures were being followed and identified isolation records had been amended retrospectively.

Once more, there was a missed opportunity to hear directly from children and young people affected in a critical incident investigation, which at the very least, would have alerted children and young people at the Centre that some action was being taken to assess the appropriateness of their treatment during and following the December 2019 roof incident. We suspect that, if asked, Arlo, Elijah and Joseph would have believed they were unit bound as punishment for their involvement in the roof incident. We saw no evidence there was an acknowledgment or apology by the Department for the extended, and potentially unauthorised, isolation that Arlo, Elijah and Joseph experienced over the weekend, or an assessment of potential harm caused.



## 10.6 The Department's response to the independent investigation

On 22 December 2021, Secretary Pervan cleared an Issues Briefing to the Minister for Children and Youth, which provided updates on a series of concerns raised about Ashley Youth Detention Centre in 2020, via the Office of Cassy O'Connor MP.<sup>1882</sup>

Relevantly, the Issues Briefing, as cleared by Secretary Pervan, stated that regarding:

- the lack of authorisation to put children into isolation after the December 2019 roof incident and the alteration of documents, 'the incident has been externally investigated' and the 'investigation has been finalised and appropriate action taken'<sup>1883</sup>
- the allegation that Mr Ryan had directed or pressured other staff to forge or backdate paperwork in relation to isolation records, '[t]his incident has been independently investigated and finalised, per the above information'.<sup>1884</sup>

It is not clear to us that 'appropriate action' had been taken in relation to the matter, nor that the matter had been 'finalised'. We understand that various disciplinary processes related to the matters raised in the independent investigation report remained underway at the time of this Issues Briefing. We were advised the Department had either 'acted or is waiting to take action' against each of Mr Ryan, Maude and Chester regarding the roles they played in the December 2019 roof incident.<sup>1885</sup> A summary of the status of each matter, as we understand it, is set out next.

### 10.6.1 Department's response to Mr Ryan

In October 2021, the Department decided not to engage with Mr Ryan regarding the matter, due to health and wellbeing concerns.<sup>1886</sup> On 17 February 2022, Department representatives met with Mr Ryan to discuss concerns raised in the independent investigator's report, including that Mr Ryan had:

- failed to apply the instrument of delegation appropriately under the Youth Justice Act<sup>1887</sup>
- applied pressure on employee/s to complete isolation authorisation forms, knowing the Isolation Procedure had not been followed and approval for isolation had not been sought<sup>1888</sup>
- applied pressure on employee/s to incorrectly complete isolation authorisation forms, to show retrospective compliance with the Isolation Procedure.<sup>1889</sup>

Mr Ryan denied the allegations. The Department concluded Mr Ryan's 'actions (or inactions) most likely did not breach any internal practice guide, process or procedure'.<sup>1890</sup> The Department determined to not take any further action in relation to

the matter.<sup>1891</sup> The reason given for not pursuing an Employment Direction No. 5—Breach of Code of Conduct investigation was that it was ‘unlikely an investigation focused on the *State Service Act 2000* would yield any further information [than] has already been obtained’.<sup>1892</sup>

This view appears inconsistent with the original purpose and scope of the independent investigation and calls into question the necessity and usefulness of carrying out a lengthy investigation in the first place.

In a letter to Mr Ryan dated 4 April 2022, Secretary Pervan advised:

Whilst I do consider that more could have been done in relation to ensuring that correct policies and procedures were followed in relation to the events from 13 to 16 December 2019, I do not consider that further action is required by me given you are no longer assigned duties at [the Centre].

...

I consider it important that I take this opportunity to document expectations in relation to your new role as Manager Silverdome.

I would like to remind you of existing policies and procedures, specifically in relation to delegations, which are available on Communities Tasmania’s intranet. I would like to outline to you that it is important that you obtain written clarification if, at any time, you require clarification in relation to these.<sup>1893</sup>

### 10.6.2 Department’s response to Chester

In or around late 2021, representatives of the Centre and the Department’s People and Culture team met with Chester to discuss allegations that he had:

- backdated and signed isolation authorisation documents relating to the December 2019 roof incident, knowing that they were incorrect and to retrospectively show compliance with the Isolation Procedure<sup>1894</sup>
- prepared backdated isolation authorisation documents for staff who worked between 13 and 16 December 2019, to retrospectively show compliance with the Isolation Procedure.<sup>1895</sup>

We were advised that, as of August 2022, the Department’s People and Culture team was still waiting to finalise Chester’s statement due to his significant absences from work since the meeting.<sup>1896</sup>

### 10.6.3 Department’s response to Maude

We were told the Department has concerns that Maude pressured Chester to backdate and sign isolation authorisation forms relating to the December 2019 roof incident, knowing they were to retrospectively show compliance with the Isolation Procedure.<sup>1897</sup> We understand those concerns had not been put to Maude as Maude was suspended from her employment for other reasons.<sup>1898</sup>

#### 10.6.4 The Department's response to system issues

Ms Honan advised us that the report of the independent investigation into the December 2019 roof incident was not shared with her until 19 May 2021, some weeks after its 26 March 2021 completion.<sup>1899</sup> She stated that no specific action was taken in response to the findings, on the basis that 'many of the issues and considerations identified ... had been addressed or were [a] work in progress as previous recommendations in [Serious Event Review Team] reviews'.<sup>1900</sup> She identified these steps as including:

- changes to incident reporting and review
- changes to leadership and collaboration across teams
- clarification of the isolation process
- supporting staff to work in compliance with policy and procedures.<sup>1901</sup>

Ms Honan noted that such an incident would now be managed in a completely different way, and that:

- all staff, including managers, are 'now informed' about procedures concerning the use of force, isolation and delegation and would obtain necessary authorisations consistent with those procedures<sup>1902</sup>
- incident reporting is now managed electronically and is centralised, 'requiring more timely and comprehensive details with multiple review delegations' and resulting in greater transparency and accountability<sup>1903</sup>
- the unit bound practice and Blue Program are no longer in use at Ashley Youth Detention Centre.<sup>1904</sup>

At our public hearings, Ms Honan expressed confidence the unit bound practice and Blue Program were no longer in use at the Centre.<sup>1905</sup> When asked what gave her such confidence, she said:

I think there's several aspects to it. One of them is that the staff that were authorising it and condoning it as a legitimate practice are no longer there. The staff that are there, i.e. the new managers have—it's been very clear with them and from them with staff. There is much clearer documentation and accountability around practices and procedures, and as an independent, I guess, litmus test and validation that these practices are no longer used we're fortunate to have the Commissioner for Children have an advocate that's also on site three days a week often, sometimes a little less but often frequently; the Commissioner herself is up there on a monthly basis and I have every confidence that the young people would speak up if this was a practice that was occurring.<sup>1906</sup>

Secretary Pervan noted a key response to the December 2019 roof incident was to replace the Isolation Procedure with a 'new directive', although he did not describe what that new directive entailed.<sup>1907</sup> He also identified the following steps taken in response to the December 2019 roof incident:

- the development of an *Ashley Youth Detention Centre Practice Framework* ('Practice Framework') and *Learning and Development Framework* (we discuss these documents in Chapter 12)
- 'upgrade[s]' to the training coordinator role
- the development of new policies and procedures in line with the Practice Framework
- the provision of oversight and risk assessment activities by the Multi-Disciplinary Team alongside the 'development of appropriate safety planning and behaviour management'.<sup>1908</sup>

Secretary Pervan did not provide further detail about what these developments involved in practical terms.

We are aware that in December 2021, the instrument dealing with delegation of authorities and powers at the Centre was revised. Critically, the revised delegation instrument provides as follows:

- The Assistant Manager of the Centre is a delegate who may exercise the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act.<sup>1909</sup> That delegation is not subject to any conditions.<sup>1910</sup>
- The Director, Strategic Youth Services or the Centre Operations Manager may exercise the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act, only if the Centre Manager and the Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'.<sup>1911</sup>
- An Operations Coordinator may exercise the Centre Manager's power to isolate a young person in line with section 133(2) of the Youth Justice Act. However, the delegation does not extend to authorising isolation for a period of more than 30 minutes.<sup>1912</sup>
- A youth worker may exercise the Centre Manager's power to isolate a young person in line with section 133(2) of the Youth Justice Act. However, the delegation is only to be exercised if the delegate is performing the duties of the Operations Coordinator and does not extend to authorising isolation for a period of more than 30 minutes.<sup>1913</sup>

## 10.7 Our observations

We note, with concern, the following aspects of the immediate response to the December 2019 incident, including that:

- The Operations Team seemed to understand the purpose of isolating Arlo, Elijah and Joseph to be punishment, despite isolation as punishment being prohibited under the Youth Justice Act and the Isolation Procedure.<sup>1914</sup>
- A number of staff believed isolating Arlo, Elijah and Joseph over the weekend after the incident was being carried out under the Blue Program.<sup>1915</sup> Mr Ryan denied he had instructed staff to use the Blue Program for Arlo, Elijah and Joseph.<sup>1916</sup> However, the independent investigator found the youth workers ‘had the Blue Program in mind’ when preparing the individual programs for Arlo, Elijah and Joseph.<sup>1917</sup> This suggests the Blue Program remained in use (at least informally) at the Centre until at least the end of 2019.
- One youth worker, with more than a decade’s experience at the Centre, told the independent investigator his understanding of isolation procedures was ‘very blurred’.<sup>1918</sup> It is concerning that a youth worker with this degree of experience was not clear on how isolation practices should work at the Centre.

We are concerned that some problems with the Isolation Procedure remain. Revisions to the delegation instrument in 2021 expand the number of delegates who may exercise the power to isolate a young person under section 133 of the Youth Justice Act. However, this revised version of the instrument does little to clarify the circumstances in which the Centre Manager or Assistant Manager are ‘on leave, uncontactable, or unable for any other reason to perform the relevant function’. It is unclear why such clarifications have not been made, given this was one of the issues raised in the 2019 investigation. It is concerning, too, that this phrase is a condition of many other delegated powers, including in relation to searches.

Despite the claims of clearer documentation or improved training and understanding about isolation procedures, we also query the extent to which the Isolation Procedure and associated delegations reflect current practice. Specifically, we note that Stuart Watson, Centre Manager, stated that extensions of periods of isolation beyond three hours may be approved by the Director.<sup>1919</sup> Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, similarly expressed the view that extensions of isolation periods beyond three hours require authorisation from the Director.<sup>1920</sup> These responses do not reflect:

- the Isolation Procedure, which only requires that the Centre Manager consult the Director<sup>1921</sup>

- the wording of the Authorisation for Extension of Isolation form, which states that '[e]xtensions beyond [three] hours from initial time of Isolation requires that the Detention Centre Manager (or Delegate) review and consult with [the Multi-Disciplinary Team] and Director'<sup>1922</sup>
- the conditions of the 2021 delegation instrument, which provides that the Director may only exercise the power to isolate a young person under section 133(2) of the Youth Justice Act in instances where the Centre Manager and Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'.<sup>1923</sup>

We commend an approach that seeks to ensure that extensions of isolation periods beyond three hours receive a high level of authorisation and oversight, given the serious nature of such a practice. However, we are unaware of any written requirement that complements the Isolation Procedure or the 2021 delegation instrument and requires the Director's approval to extend a period of isolation.

We are concerned that despite revisions to the delegation instrument, a common understanding of who has the power to authorise isolation, and in what circumstances, appears to remain elusive to Centre management and Department officials.

## 11 Roof incident March 2020

In March 2020, there was another incident where young people at the Centre gained access to a roof. Ms Honan, Director, Strategic Youth Services, told us this incident threatened the safety of staff and other young people because of the number and unpredictability of the young people involved.<sup>1924</sup> The Centre's response again involved isolation. We discuss the incident and response next in relation to isolation practices. Other concerns were raised regarding this incident, including allegations of harmful sexual behaviours and workplace health and safety concerns, but we have focused on isolation practices. We were unable to find consistent evidence in relation to the allegations of harmful sexual behaviours, and therefore do not address those matters.

The incident and the response demonstrate continued confusion about appropriate ways to respond to children and young people and the use of isolation practices. We understand the relevant isolation policy at the time of the incident was the Isolation Procedure, which is presently in force and described in Section 2.<sup>1925</sup>

## 11.1 The incident

On Friday 6 March 2020, staff and young people at Ashley Youth Detention Centre were threatened by four young detainees, who also caused property damage.<sup>1926</sup>

At approximately 2.30 pm, four young people jumped the inner yard fence at the Centre and climbed onto shipping containers at the back of the Ashley School building.<sup>1927</sup> A request for assistance ('code black') was called and available staff responded by positioning themselves to block possible exit routes from the space.<sup>1928</sup> Staff began to negotiate with the young people but were unsuccessful.<sup>1929</sup>

The young people made a hole in the roof of a shipping container and found items stored inside they could use as weapons.<sup>1930</sup> They threatened to harm any staff member who approached them and threw small objects at staff.<sup>1931</sup> Eventually, the young people jumped from the roof of the shipping container armed with hammers and metal bars, and staff moved inside the Centre to keep safe.<sup>1932</sup> The young people then gained entry to the stores building and, while armed with makeshift weapons, climbed onto the roof of the Bronte Unit and continued to threaten staff from there.<sup>1933</sup>

At that time, three staff members and four other young people were inside the Bronte Unit.<sup>1934</sup> A decision was made to evacuate the Bronte Unit.<sup>1935</sup> Staff and two of the young people inside the unit were evacuated first.<sup>1936</sup> When staff returned to evacuate the two remaining young people, staff found they had entered the roof cavity of the unit with the help of the four young people who had broken through the external roof.<sup>1937</sup>

The incident report suggests police were notified, asked to attend and arrived on site at about 4.30 pm.<sup>1938</sup> At approximately 5.00 pm, two young people left the roof and again attempted to gain access to the stores building, where they were restrained by police.<sup>1939</sup> Both were temporarily placed in the admissions holding cell before being escorted to their respective rooms.<sup>1940</sup> Both young people were seen by the Centre's nurse.<sup>1941</sup>

The four remaining young people stayed on the roof for about five hours more.<sup>1942</sup> They continued to make threats, as well as sexual comments, to staff and police, and were still armed with makeshift weapons.<sup>1943</sup> One young person gained access to a circular saw.<sup>1944</sup> The four young people then broke into the Bronte Unit's staff office, accessing the security drawer.<sup>1945</sup> At approximately 6.30 pm, police with shields were moved into the Centre.<sup>1946</sup> A member of the Professional Services Team attempted to contact the families of the young people involved in the incident.<sup>1947</sup>

At about 10.00 pm, one young person came down from the roof, escorted by police.<sup>1948</sup> The three remaining young people made a series of demands, including for pizza and bottles of Coke.<sup>1949</sup> They also asked for guarantees about the unit they would be moved to, that they would not spend any time in their rooms, and that they would be allocated a 'yellow' colour status under the Behaviour Development System.<sup>1950</sup> The young people received the requested food and drink and were assured that they would be placed in the unit of their choice once they came down from the roof.<sup>1951</sup>



By 11.00 pm, all remaining young people had come down from the roof.<sup>1952</sup> They were escorted by police to their unit with no injuries, and their families were notified of the safe conclusion of the incident.<sup>1953</sup>

We understand that all young people detained at Ashley Youth Detention Centre who were not involved in the incident were confined to their units during the incident—about eight-and-a-half hours.<sup>1954</sup>

We note this incident occurred just before the 11 March 2020 announcement by the World Health Organization that COVID-19 was a pandemic.<sup>1955</sup>

## 11.2 Disagreement about the Centre’s response

Mr Ryan was the Centre Manager on the day of the incident. He told us he was very stressed at the time and, aside from a few hours the following Wednesday, after days off and sick leave, this major incident occurred on his last day of employment at Ashley Youth Detention Centre.<sup>1956</sup>

Soon after the March 2020 roof incident, Stuart Watson took over as Acting Manager of Ashley Youth Detention Centre.<sup>1957</sup> He was appointed permanently to the position of Manager, Custodial Youth Justice (‘Centre Manager’), in March 2021.<sup>1958</sup>

Towards the end of and immediately following the incident, there was a dispute between Ms Honan and the Centre’s management about how the young people involved in the incident should be managed over the following days. We understand that Mr Ryan as Centre Manager, Mr Watson, then the Assistant Manager, Piers, then the Acting Operations Manager and Ms Atkins, as On-Call Manager over the weekend, were involved in telephone discussions with Ms Honan. We received different accounts of this discussion.

Mr Ryan told us he shared many phone calls and emails with Ms Honan as the incident unfolded and once it had concluded.<sup>1959</sup> This included an email from Mr Ryan to Ms Honan on the day of the incident, Friday 6 March.<sup>1960</sup> Mr Ryan added he called meetings with senior staff during the incident about planning for the weekend, and he told senior staff to raise the plans with Ms Honan.<sup>1961</sup> Mr Ryan stated Ms Honan provided no support in relation to how the young people could be managed, but he did not elaborate on this.<sup>1962</sup>

Ms Honan’s evidence was that, at about 9.00 pm on the evening of the incident (before it had concluded), Mr Ryan and Ms Honan corresponded about the planned approach to the young people over the weekend.<sup>1963</sup> She provided us with copies of some of that correspondence.<sup>1964</sup> Ms Honan explained that Mr Ryan proposed ‘a combination of rolling isolation and unit bound practices for the proceeding [three] day, long weekend for all of the young people involved in the standoff’.<sup>1965</sup> This is evidenced by copies of ‘program forecasts’ that Mr Ryan provided to Ms Honan on the evening of 6 March 2020,

which he described as involving ‘multiple [i]solations’, whereby ‘[e]ach resident would be effectively in and out of their room, but collectively [isolated for] more than 3 hours per day’.<sup>1966</sup> Ms Honan told us she considered this to be a similar response to that used after the December 2019 roof incident, except the approach was provided to Ms Honan to ‘endorse’.<sup>1967</sup> Ms Honan’s evidence was that Mr Ryan gave no reasons for the need to use isolation and unit bound procedures in this way.<sup>1968</sup> In her view, there were too many ‘unknown factors’ at that time, as the incident was still ongoing, making the proposal ‘premature’.<sup>1969</sup>

Ms Honan emailed Mr Ryan, stating: ‘[h]aving ... compare[d] [Mr Ryan’s proposed response] to the isolation procedure ... the more uncomfortable I am with it’.<sup>1970</sup> Ms Honan proposed an alternative approach, which included a combination of placing the young people on ‘red’ colour ‘once the initial immediate isolation procedure is expired’ and ‘[r]estricted activity and closer supervision but not constrained to rooms’.<sup>1971</sup> She requested that Mr Ryan reassess the situation the next morning.<sup>1972</sup> Ms Honan said she received a further proposal from Mr Ryan at 10.21 pm on the night of 6 March 2020, asking her to endorse it.<sup>1973</sup> Ms Honan told us that at the time she would not endorse the proposal and instead told Mr Ryan he should rely on the expertise of the Centre’s management and the Professional Services Team to determine the best way forward.<sup>1974</sup>

During a later discussion about the incident with Department officials, Digby (a pseudonym), a former Manager, Professional Services and Policy, said the discussion centred on Ms Honan’s proposal of a ‘reset’ based on a therapeutic approach and his and others’ focus on ‘de-escalation and restoration, which is a critical part of any therapeutic approach’.<sup>1975</sup> He expressed concern the direction being proposed was ‘a new way for which there had been no training, no guidelines, policies or procedures, no practice experience’.<sup>1976</sup>

During our hearings, Mr Watson said he also considered the plan proposed by Mr Ryan and others was inappropriate.<sup>1977</sup> Mr Watson stated the correct approach would have been to have rehabilitation at front of mind.<sup>1978</sup> He explained the starting point should be that if the young person was non-violent, non-aggressive and non-threatening, they should be out of their room.<sup>1979</sup> He considered this approach gave young people a chance to rehabilitate and ‘move forward’.<sup>1980</sup>

Ms Honan conceded to us that appropriate management of young people was not her area of expertise, and that four or five staff employed at the Centre in addition to Mr Ryan did have the expertise and operational knowledge required to inform the approach.<sup>1981</sup> We note the Isolation Procedure provides that, for isolation periods extending beyond three hours, the Centre Manager or their delegate should ‘consult’ with various professionals at the Centre and speak with the Director about the outcome of those consultations. This suggests there is no expectation the Director would have specialist knowledge to inform isolation decisions.

It seems apparent there was no agreed policy or procedure being used to guide the response. However, we agree with the observations of Ms Honan that, when read alongside the Isolation Procedure, the proposed approach was concerning and there was no clear rationale for isolation at that time.

### 11.3 The Centre's response: isolation and unit bound

The evidence available to us indicates the six young people involved were all unit bound for at least four days after the incident, with some unit bound for as long as seven days.<sup>1982</sup>

Ms Honan's evidence was that the eventual approach taken towards the young people involved in the incident partly reflected her suggestions.<sup>1983</sup> She considered the Isolation Procedure was followed appropriately in the days following, as decisions to isolate the young people were 'based on immediate risk and safety assessment[s]' and were authorised by herself and the On-Call Manager where extensions beyond three hours were required.<sup>1984</sup>

According to Mr Watson, the young people were not punished but were dropped to 'red' on the Behaviour Development System.<sup>1985</sup>

The day after the incident, Ms Atkins, Coordinator, Admissions and Training at Ashley Youth Detention Centre at that time, emailed Ms Honan regarding 'continued and ongoing risks ... if all young people are to associate'.<sup>1986</sup> Ms Atkins highlighted, among other things, that:

- there were several young people who had intended to take part in the incident and there was talk among the young people of retribution for those who did not get involved
- at that stage, staff had indicated that if 'all young people' were to be allowed out of their rooms, six staff would 'walk off', leaving the Centre significantly understaffed
- one young person was believed to have a weapon at that time
- significant damage to the Bronte Unit meant it could not be used in the near future.<sup>1987</sup>

Ms Honan responded to Ms Atkins' email, welcoming the new information, classifying it as serious, and stating that it 'change[d] the position significantly'.<sup>1988</sup> She noted she 'absolutely support[ed] the staff concerns'.<sup>1989</sup>

We understand all young people were locked in their rooms until at least 3.00 pm on Saturday 7 March 2020.<sup>1990</sup> The next day, Sunday, a fight broke out between some young people who had been involved in the incident and some who had not.<sup>1991</sup> The related incident report stated that before the fight, young people not involved in the roof incident had been:

... [expressing] resentment towards the residents who had caused them to be unjustly locked in their rooms for 8 hours on Saturday morning [7]th of March [and] saying it was unfair [the] roof incident didn't come with consequences as many had consequences in the past for ... similar behaviour.<sup>1992</sup>

Staff held a debrief meeting in the days following the 2020 roof incident, which was also attended by an external counsellor.<sup>1993</sup> Mr Watson, Mr Ryan, Ms Atkins and Ms Honan did not attend this meeting, but Piers did.<sup>1994</sup> In the debrief, staff commented that management had handled the situation well, praised how staff supported one another during the incident and commended the Professional Services Team's response over the weekend following the event.<sup>1995</sup> The debrief minutes identified there was a '[h]istory of [young people] doing stand offs with no consequence for [their] action[s]'.<sup>1996</sup> The minutes also indicated that the staff felt that the overall understanding of the Isolation Procedure could be improved.<sup>1997</sup>

The debrief minutes contained a series of other recommendations and observations. Specifically, the staff sought an explanation from management or the Director about why the decision was made to lock down all the young people in the Centre and not just the young people involved in the incident.<sup>1998</sup>

## 11.4 The Department's response to the incident

We are not aware of a formal investigation being conducted specifically into the isolation of children and young people after the March 2020 roof incident. We understand there was an internal review of 'the serious incident on 6 March 2020 itself,' but this was more limited than the investigation into the 13 December 2019 roof incident discussed in Section 10 (which considered the extended series of events following the incident, including staff responses).<sup>1999</sup>

## 11.5 Reforms since March 2020

Ms Honan gave evidence there had been changes at Ashley Youth Detention Centre since the March 2020 incident.<sup>2000</sup> She highlighted changes to the Practice Framework, which outlines a model of care provided at the Centre. Ms Honan reflected that the Practice Framework in place at the Centre at the time of the 2020 roof incident had grown organically and she considered that there were not 'many people that had any clarity about ... the practice framework across the Centre, and they had selectively picked pieces out of it or operated almost autonomously ... under intuition'.<sup>2001</sup> She acknowledged youth workers did not understand or use the Practice Framework in appropriate ways.<sup>2002</sup>

Soon after the incident, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, in partnership with Southern Cross University, prepared a report for the Department titled *Through the Fence and into*

*Their Lives: Ashley Youth Detention Centre Trauma Informed Practice Framework*, dated April 2020.<sup>2003</sup> We discuss this report in Chapter 10 but note here that it proposes a ‘scope of works and methodology for the further development and implementation of an integrated and tailored practice framework’.<sup>2004</sup>

Ms Honan also discussed the siloed nature of the working relationship between the Operations Team and the Professional Services Team, and considered that if staff were to respond to a similar event today, they would do so in a more collaborative way.<sup>2005</sup> She further stated a more trauma-informed practice at the Centre had ‘evolved’ from the recommendations of the *Through the Fence* report.<sup>2006</sup>

On 26 March 2021, Secretary Pervan received the report of the independent investigation into the December 2019 roof incident, which we describe in Section 10.

## 11.6 Our observations regarding the March 2020 roof incident

It is apparent from the evidence available to us, including the concerns Ashley Youth Detention Centre staff raised with Ms Honan, that there was a high level of stress and tension among staff following the March 2020 roof incident, as well as a lack of understanding about the decisions made in response to the incident and the reasons for them. It appears the lack of understanding was partly due to insufficient training in responding to major incidents (which we have not discussed here). There was also a lack of understanding of the therapeutic framework intended to guide the response.

Of particular concern, the minutes of an all-staff meeting following the incident recorded the view that staff needed to improve their understanding of, among other things, the Isolation Procedure and that associated training was required.<sup>2007</sup> Most of the staff who attended this debrief had (at that point) been working at the Centre for a substantial number of years, some for more than a decade.<sup>2008</sup> As we noted earlier in our system observations of the December 2019 roof incident, it is alarming that staff members who had worked at the Centre for a significant period felt the need to improve their understanding of important procedures such as the Isolation Procedure.

We were also left with an overwhelming sense that a clear and measured response to the March 2020 roof incident was hampered by workplace tensions. The distress and concerns of staff about the response to the incident were no doubt heightened by the lack of any cohesive or communicated response plan by management and disagreement between senior decision makers.

This degree of dysfunction at the Centre at a senior level and in relation to long-term staff members’ ignorance of key procedures relevant to managing young people in detention after incidents of this kind, has put children and young people in detention at risk. It is unacceptable that experienced staff members at the Centre and the

Department do not have the knowledge or skills to respond decisively, lawfully and effectively to incidents that threaten the security of the Centre. It is also not acceptable that management cannot provide decisive, lawful and effective guidance to staff when confronted with an incident of this nature because they are engaged in disputes among themselves about what constitutes a lawful and appropriate response.

We found it difficult to know whether, after these 2020 reforms by the Department, the necessary cultural change had occurred to stop what appeared to have been a systematic use of isolation outside parameters set by international conventions since the Centre was established. We acknowledge Secretary Pervan's evidence of policy change and workforce development to address the issue but note these were strategies that had been trialled repeatedly in the past and failed to create sustained change. We also recognise the evidence of Ms Honan that the changes that gave her confidence inappropriate isolation practices were no longer occurring were that 'the staff that were authorising it and condoning it as a legitimate practice are no longer there'. We were also somewhat reassured by the regular presence at the Centre of the Commissioner for Children and Young People and her advocate, until we received further evidence from the Commissioner in July 2023 (refer to discussion in Section 13).

## 12 The Department's response to the use of isolation at Ashley Youth Detention Centre

In response to our requests for information, as well as during our public hearings, Secretary Pervan provided several explanations to us about the use of isolation practices—historically and recently—at Ashley Youth Detention Centre.

We asked Secretary Pervan to comment on whether it was appropriate to isolate a young person in detention in the manner described in *Lusted v ZS*.<sup>2009</sup> He responded that '[u]nder no circumstances is the isolation of a young person as described in the case of *Lusted v ZS* appropriate'.<sup>2010</sup> He observed that the staff member who acted to isolate the young person in that case was relying on an 'incorrect' interpretation of the Youth Justice Act.<sup>2011</sup>

Secretary Pervan was also asked whether the isolation of Z, as described in *Lusted v ZS*, was accurately recorded in the isolation register. He responded:

No. Records from 2013 were stored in physical hard copy files in a locked filing cabinet and in excel spreadsheets which were stored on an external hard drive. The information on the forms during this period was minimal and often not populated or signed off. With respect to this case, the records appear incomplete and have been inaccurately recorded in the isolation register. This may not have



been classified as 'isolation'. A practice developed known as the 'Blue Program' which was known to be for purported restricted movement and unit bound. The 'Blue Program' was not a formalised or approved program and was not contained in any policy or procedure documents from the time. It does appear, however, that it had some level of acceptance among [Centre] staff as being operationally utilised at that time.<sup>2012</sup>

In a further request for statement, we asked Secretary Pervan to explain the meaning of 'unit bound'. He explained that:

... unit bound is ... the situation where a resident, as a result of decisions made in response to the specific needs and behaviours of the resident, is not scheduled for activities outside the unit and therefore remains within the unit. The resident is not locked into their rooms nor kept from contact with other residents although there may be restrictions on contact with specific residents. Unit bound is not a formal status, and there is no specific policy governing it, but is a description of the current circumstances of the resident.<sup>2013</sup>

Secretary Pervan added that when a young person is unit bound, they continue to have an educational program, which is monitored through the Multi-Disciplinary Team.<sup>2014</sup> Depending on risk assessment, some aspects of the educational program (for example, the Ashley School woodworking program, which involves sharp tools) may not be available.<sup>2015</sup> He continued:

In the past, 'unit bound' has been used interchangeably with the terms 'separate routine' and 'individual program', both of which appeared on early versions of the isolation procedure and have been, at times, used in a manner similar to the Blue Program ...<sup>2016</sup>

In the next paragraph of his statement, Secretary Pervan explained:

[The Blue Program] ... was intended to be for tightly restricted movement and unit bound detainees. A Blue Program appears to have been in place in 2013 and a version of the Blue Program was put into place as a category within the framework of the Behaviour Development System. It was inserted into a draft (Version 2.8) for a period in 2019 and implemented within [the Centre]. Neither the Blue Program nor the Blue category were approved by the Department. The Blue category of the [Behaviour Development System] was implemented within [the Centre] without agency approval. The Blue Program and the Blue category are both based on incorrect interpretations of policies and procedures to manage behaviours. They are unlawful (in my personal view) and inconsistent with approved practice.<sup>2017</sup>

When discussing the present status of the unit bound practice and the Blue Program, Secretary Pervan said:

In short, the use of the Blue Program and unit bound have been ceased and replaced by a Use of Isolation procedure that is monitored and enforced. I am also aware that the Commissioner for Children and Young People monitors the use of isolation and is regularly provided with data to enable that monitoring.<sup>2018</sup>



In the same statement, Secretary Pervan commented on how decisions are made regarding the use of isolation practices. He said:

I do not have concerns in regard to how decisions are made in relation to the use of isolation, where isolation is recognised as isolation. There should be no decision made to implement a Blue Program or category under the Behaviour Development System.

As stated above, ‘unit bound’ is a term to describe the circumstances in which some restrictions on the participation of the resident outside their unit have been put into place as a result of the [Multi-Disciplinary Team]. I do not have concerns about the procedure for the operation of the Multi-Disciplinary team or the decisions made by that team. It may be however that the term ‘unit bound’ should perhaps be replaced with another term which has less historical associations and better describes the current program for the young person concerned.<sup>2019</sup>

In a discussion about whether isolation could constitute torture, Secretary Pervan stated:

Without wanting to go to a specific case, only because I don’t have that detail in front of me, as I understand—and it’s a superficial understanding—the definition of ‘torture’ in that document goes to intent, and there was, I believe, looking at the past, a use of restrictive practice to—it would be argued by the staff involved it was used as a disciplinary measure, but yet the intent was to cause people to feel bad, it wasn’t for their safety, it wasn’t for any other purpose but to punish them.<sup>2020</sup>

In his written evidence to our Commission of Inquiry, Secretary Pervan stated unequivocally that both the Blue Program and unit bound were no longer in use at Ashley Youth Detention Centre. However, he expressed his faith in the discretion of the Multi-Disciplinary Team at the Centre to limit the participation of a young person in activities of the Centre and advocated for a new term for the practice. This raises significant concerns that unit bound practices, in some form, continue to be used at the Centre, despite representations to the contrary.<sup>2021</sup> We hold serious concerns that practices substantively similar to unit bound, and involving isolation of a young person within the plain meaning of the term, may still be continuing at the Centre, given the long-term and systematic use of unit bound over previous years.

In her evidence to us, Ms Atkins, Assistant Manager at Ashley Youth Detention Centre, referred to *Standard Operating Procedure No. 15* as current policy. This procedure states, in part, the following:

#### Separate Routine

A young person may be placed on a Separate Routine where their behaviour presents a risk to others or to the security of the Centre but which can be managed without resort to isolation. It may involve restrictions on contact with other specific young people or certain programs and areas of the Centre. It may also entail closer supervision and/or restriction to a particular Unit. This strategy can be used to deal with risks such as threats of harm to self and others, threats of escape and

subversive and inciting behaviour. A Separate Routine can only be approved by the [Centre Support Team] or [Interim Centre Support Team], must be reviewed at least twice a week and must be discontinued as soon as the level of risk permits.<sup>2022</sup>

We note the description of ‘separate routine’ in the Centre’s current procedure reflects the exact wording quoted to Mr Morrissey by the Acting Deputy Secretary, Children and Youth Services, in November 2016, when he sought clarification on the use of unit bound practice on two young people. As discussed above, that response from the Acting Deputy Secretary acknowledged:

- the terms ‘unit bound’, ‘separate routine’ and ‘individual program’ were often used interchangeably
- separating a young person from other young people at the Centre was concerning
- a revised policy was being prepared to resolve the different ‘designations’ being given to essentially the same practice.

Critically, the Isolation Procedure at Ashley Youth Detention Centre does not appear to have been revised to resolve the different designations, nor to articulate that what is, in substance and effect, a practice of isolation (even if it is part of a broader program that is not associated with the Isolation Procedure) must accord with legislative requirements. Further, there do not appear to be any safeguards currently in place, besides the consideration of the Multi-Disciplinary Team, to ensure that young people are only held in isolation while being unit bound or on ‘separate routine’ in line with the Youth Justice Act.

We note the contradictory evidence of Secretary Pervan regarding the potential use of unit bound and the Standard Operating Procedure regarding ‘separate routine’, which suggests the policy conditions that enabled potentially unlawful isolation practices to become systematic still prevail.

We further note that since 2020, children and young people detained at the Centre have experienced significant periods of isolation for operational reasons, due to the impacts of the COVID-19 pandemic and staff shortages. We note that following a visit to the Centre in November 2022, the United Nations Committee against Torture (responsible for monitoring the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) stated that it was ‘seriously concerned’ about the use of isolation practices at the Centre.<sup>2023</sup> The committee also stated it considered that current practices contravened the Convention and the associated United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Nelson Mandela Rules).<sup>2024</sup>

## 13 Isolation practices in 2023

In July 2023, Commissioner McLean informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, and that isolation practices continued to be used at the Centre.<sup>2025</sup> She advised that over the previous six months, her office had observed (among other practices):

- Individual young people being referred to as ‘unit bound’ by staff during conversations, on office noticeboards, and in Weekly Review Meeting ... minutes;
- The extended use of unit-specific lockdowns ... and the extended isolation of individual young people, with one young person likening these practices to the ‘Blue Program’;
- Moving or threatening to move young people to units that experience more frequent lockdowns as a means of responding to and/or managing behaviour;
- The reintroduction of ‘quiet time,’ which sees young people restricted to their rooms every day between 12:30pm – 1:15pm, sometimes without staff being present in the unit ...<sup>2026</sup>

This is extremely concerning.

In response to Commissioner McLean’s comments, the Government acknowledged that restrictive practices continued to occur at Ashley Youth Detention Centre due to staff shortages (discussed in Chapter 12).<sup>2027</sup> Timothy Bullard, Secretary, Department for Education, Children and Young People, also stated:

The [Commissioner for Children and Young People] has expressed concern that young people at [Ashley Youth Detention Centre], particularly those in the Franklin Unit, have been locked down in response to their behaviour. I am advised that young people in the Franklin Unit have been subject to the same restrictive practices as other young people at [the Centre]. I understand that some residents may perceive that they are being treated differently if they are in their rooms while others are out of theirs. This is not the case, as restrictive practice means that young people are out of their rooms at different times of the day, depending on the number and experience of staff present in [the Centre] and the need to accommodate any association issues between young people.<sup>2028</sup>

We note that the Government’s response did not address Commissioner McLean’s observations:

- that staff were referring to individual children as ‘unit bound’
- of extended isolation of individual young people
- that daily 45-minute ‘quiet time’ had been reinstated.

As such, the Government’s response did not address all our grave concerns about the continuing use of isolation at Ashley Youth Detention Centre. As we only became aware of these concerns in July 2023, we were unable to continue to explore these specific

matters. This evidence reinforces our concerns that the cultural and policy conditions that enabled isolation practices to occur continue to exist today.

## 13.1 Our observations

We remain extremely concerned that isolation practices may be continuing at the Centre at the time of writing and there may not have been the broad sweeping cultural change required to address this.

### **Finding—The use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today**

Whether described as isolation, unit bound, the Blue Program, segregation, individual program, separate routine, time out or some other term, practices that amount to isolation have been regularly and consistently used at Ashley Youth Detention Centre over many years, despite being contrary to the legal and policy frameworks that are intended to govern the appropriate use of isolation.

The accounts of young people in detention from the early 2000s to at least the mid-2010s consistently mention unlawful and harmful isolation practices, sometimes used as routine practice (such as on admission) and sometimes used as punishment for the conduct of the young person. While we do not comment on the veracity of each individual account, we have given weight to the consistency of their accounts across many years (and the resonances they have with terminology and events in more recent years).

From 2011, the Blue Program, which adopted a practice of unit bound, existed at the Centre as part of the Behaviour Development System, but was, in the words of one longstanding staff member, ‘rescinded in December 2013 (although fondly remembered by some staff) because it had become more broadly used (for some residents who didn’t really need it) and was considered in some quarters to be a punishment option’.<sup>2029</sup>

From 2016–17, concerns were raised that at least two children in the Centre were being unit bound as punishment for their involvement in an incident at the Centre.<sup>2030</sup>

In March 2019, the Blue Program was formally reintroduced with the knowledge of the Department. This involved children and young people in detention being unit bound for excessive periods (ranging from 18 to 25 days) in response to an incident

at the Centre. While the reintroduction of the Blue Program came with warnings to staff that it was not a form of punishment, it was attached to the Behaviour Development System. Given the excessive time children spent in isolation while on the Blue Program and the program's reintroduction after an incident at the Centre, the children and young people in question must have experienced it as punishment.

In December 2019, despite the shift away from the formal Blue Program, three young people were again unit bound for 11 days in response to an incident at the Centre. They were sometimes isolated in their rooms for one hour to three or four hours at a time.

In March 2020, six young people were again unit bound in response to an incident at the Centre, some for seven days.

We note that since the COVID-19 pandemic and until as recently as August 2023, children have been subject to frequent and regular lockdown practices for operational reasons. These are another form of isolation.

Given the recent evidence we received from the Commissioner for Children and Young People, and the Department's response, we are concerned that some children and young people at the Centre may still be being placed on 'unit bound', being isolated for extended periods, and being subject to daily 'quiet time'.

We are concerned the culture of using a systematic practice of isolating children as punishment or a method of behaviour management is still a risk in 2023, particularly with the lack of clarity around policies such as the segregation procedure.

As outlined in the evidence described here, isolation practices, irrespective of their label, have often involved segregating children and young people from other children and young people, denying them the right to take part in the usual educational programming offered through Ashley School and being locked in their room or unit. Such practices create an institutional culture that increases the risk of child sexual abuse and reduces the likelihood of a young person disclosing such abuse.

## **Finding—The Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action**

We are particularly concerned the Department, and sometimes the Tasmanian Government, were put on notice several times about isolation practices that contravened both Tasmanian law and human rights principles to which Australia was a signatory, including:

- In 2013, Deputy Chief Magistrate Daly commented that a young person had been subjected to ‘isolation in a manner unauthorised by the Youth Justice Act’ and noted his concern that ‘unauthorised isolation may [be] a normal part of the management of youths in detention or on remand’.<sup>2031</sup>
- During 2016–17, the then Commissioner for Children and Young People raised multiple concerns about the practice of unit bound with the Department and the Tasmanian Government, the veracity of which was acknowledged internally by the Department in the 6 May 2016 Minute.
- In 2018, the Custodial Inspector identified serious inadequacies regarding the use of formal isolation, including the failure to:
  - regularly review and monitor instances of isolation
  - meet minimum observation requirements while young people were held in isolation
  - keep proper records, including providing a reason for the isolation.
- During 2019, the current Commissioner for Children and Young People raised questions on several occasions about the practice of unit bound and the reintroduction of the Blue Program.
- On 26 March 2021, the report of the independent investigation into the response to the December 2019 roof incident at Ashley Youth Detention Centre raised concerns about the use of isolation routines at the Centre, specifically in relation to how isolation periods were extended.<sup>2032</sup> It provided evidence the Blue Program was still believed to be used in practice, if not in name. It also raised serious questions about whether formal isolation procedures were being followed, and that there had been retrospective amending of isolation records.

- In July 2023, Commissioner McLean told us that she had written to the Department ‘persistently’ in 2022 and 2023 noting the deteriorating conditions experienced by children and young people at the Centre in relation to restrictive practices, rolling lockdowns and low staffing numbers.<sup>2033</sup> The Department acknowledged to us in August 2023 that low staffing numbers had continued to necessitate the use of restrictive practices such as lockdowns despite recent and ongoing recruitment efforts.<sup>2034</sup>

These concerns expressed by multiple entities external to the Department offered the Department, and the State, multiple opportunities to address serious concerns about the safety of children and the abuse of their human rights. We consider these to ultimately be lost opportunities. We were particularly concerned the Department failed to scrutinise why the Blue Program had previously ceased before accepting its reintroduction in March 2019. These missed opportunities meant further cohorts of children detained at the Centre were subjected to likely unlawful isolation practices.

We were also concerned that the Department’s response to queries often lacked a plain language description of the daily experience of children subjected to the practices of concern. This reflects the concern expressed by Deputy Chief Magistrate Daly that the response he received from the then Secretary was ‘so vague that it was of no practical value’ and ‘wholly inadequate’.<sup>2035</sup> These responses were accompanied by interpretations of the legal definition of isolation, which could be seen as contrary to the best interests of children and their mental and physical wellbeing.

There were also multiple occasions when concerns about isolation practices were raised in the Department. We found the 6 May 2016 Minute to be extraordinary in its sense of urgency and concern about human rights breaches, its mention of the long retention of a significant number of staff and the culture of the Centre, and its effective call for a spill of staff.

We, too, hold serious concerns about the culture of Ashley Youth Detention Centre. We do not know whether, when the Blue Program was reintroduced in March 2019, longstanding staff identified to Centre management that the Blue Program had previously been identified as unlawful and resulted in policy change during a time when they worked at the Centre, or if they voiced concerns about its use.

We consider Digby’s email comments regarding staff attitudes towards the Blue Program, including it being ‘fondly remembered’, and Ms Honan’s assessment of ‘staff that were authorising it and condoning it as a legitimate practice’ as extremely disturbing. Further, we observed in the evidence made available to us (and as described here) a continued use of the Blue Program by staff, even when it was no longer formally in use. We were gravely concerned about the culture



of resistance noted by Commissioner McLean in her correspondence suggesting this remained the case as late as July 2023 after extensive airing of concerns about these practices in our public hearings. We hold concerns that a punitive culture may have been supported and applied by some staff at the Centre, who may have taken opportunities to nullify reforms and return to more punitive practices whenever they arose. Given staffing changes, we do not know if staff who may hold a more punitive youth justice orientation continue to work at the Centre.

The Department demonstrated, at best, naivety in repeatedly addressing poor and potentially unlawful isolation through training and policy change, and accepting lack of staff knowledge as an explanation, despite many staff, including operational leaders, having long employment histories at the Centre.

The Department needs to have a clear policy on the appropriateness of providing training, counselling or direction to Centre staff members who have repeatedly demonstrated resistance to change.

### **Finding—There was a consistent failure to include the voices of children and young people detained at Ashley Youth Detention Centre in any reviews, investigations or policy changes relating to isolation**

We are concerned that too often the voices and experiences of children and young people are ignored, which can reduce their sense of safety and trust, including trust in disclosing sexual abuse. Children’s voices must be heard in decisions that affect them and be taken seriously in the application of Child and Youth Safe Standards.

While we observed two Commissioners for Children and Young People raising concerns about the Blue Program and/or being unit bound, presumably a consequence of their engagement with young people detained at the Centre, we saw no evidence that young people were ever given an opportunity to provide their experience of the Blue Program or being unit bound to people or bodies undertaking reviews of isolation practices at the Centre.

The failure to identify the benefits of engaging with and hearing the voice of children and young people about the Blue Program, particularly following the clarifications requested by Commissioners for Children and Young People, was a further missed opportunity by the Department that may have helped to identify the impact of isolation practices in the Blue Program on children and young people in detention. Because of these missed opportunities, isolation practices that were potentially outside the standards set by law, policy and international conventions continued at the Centre.

## **Finding—Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices**

Despite the many times potentially unlawful isolation practices were raised by external entities, and acknowledged internally, we saw no evidence the Department went through an open disclosure process with children and young people who were or had been in detention to acknowledge that they had been subjected to inappropriate isolation practices. Nor have we identified any records that indicate the Department sought to assess or mitigate mental health impacts of unlawful isolation practices on children and young people in detention who had experienced them.

# Case study 4: Use of force in Ashley Youth Detention Centre

## 1 Overview

As outlined in Chapter 3 and Chapter 10, the National Royal Commission identified that some institutional contexts significantly increase the risk of child sexual abuse occurring.<sup>2036</sup> The National Royal Commission described ‘closed’ institutions as presenting the highest risk of child sexual abuse.<sup>2037</sup> Youth detention centres are characteristically ‘closed’ institutions.<sup>2038</sup>

The National Royal Commission described how closed institutions can become ‘alternative moral universes’, where the institution wholly establishes and maintains its own norms and rules.<sup>2039</sup> Acts of sexual abuse against children and young people are more common where the ‘alternative moral universe’ of an institution:

- fosters a culture of tolerance for humiliating and degrading children
- routinely uses force or violence against young people
- normalises aggression.<sup>2040</sup>

Research also shows that in institutions where the routine use of force or violence against young people is permitted, staff can become desensitised. This makes it easier for them to minimise the seriousness of, or tolerate, ongoing harm, including sexual harm, to children and young people.<sup>2041</sup> Where trust is undermined, children and young people are unlikely to disclose abuse when it occurs.<sup>2042</sup>

In this case study, we consider the use of force at Ashley Youth Detention Centre. First, we consider the laws and policies governing the use of force, which reinforce that the use of force against a child in detention is only permitted in exceptional situations.

Next, we consider what victim-survivors told us about their experiences of the use of force while in the Centre from the early 2000s to the early 2020s. This is a summary of the evidence we outline in Case study 1. While we do not test the veracity of these individual accounts, we draw conclusions about their consistency, including force being used as punishment and a method to sexually abuse children. Viewed as a whole, these accounts suggested a pattern of some staff using force instead of de-escalation techniques to manage young people’s behaviour at the Centre.<sup>2043</sup>

We then discuss a series of instances where excessive force was used at the Centre during 2016–17, which echoed the direct accounts we heard in relation to failures to use de-escalation techniques in managing young people’s behaviour. We discuss several

reviews into these examples of the use of force during 2016–17, which raise concerns about whether the Department and the Tasmanian Government have always responded adequately to the inappropriate use of force.

## 2 The law and policies

International law prohibits the use of restraint or force against young people in detention, other than in exceptional circumstances.<sup>2044</sup> The *Youth Justice Act 1997* ('Youth Justice Act') prohibits the use of physical force against young people in detention, unless the force is reasonable and necessary to prevent harm to the young person or anyone else, or for the security of the detention centre, or is otherwise authorised.<sup>2045</sup>

The *Inspection Standards for Youth Custodial Centres in Tasmania* ('Inspection Standards') provide that force must only be used 'when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted'.<sup>2046</sup> The Inspection Standards also state:

- the use of force must only occur for 'the shortest time required'<sup>2047</sup>
- force should never be used as punishment or to obtain a young person's compliance<sup>2048</sup>
- force should never be used to humiliate or degrade a young person<sup>2049</sup>
- all instances of the use of force should be recorded, investigated and reported<sup>2050</sup>
- cameras should be used to record planned interventions involving the use of force<sup>2051</sup>
- a young person who has been subjected to a use of force should be given health care after the incident.<sup>2052</sup>

The Inspection Standards also require that only approved techniques and restraints should be used. The young person should be given an opportunity to speak with staff who were not involved in the incident after the use of force.<sup>2053</sup>

The use of force at Ashley Youth Detention Centre is also guided by the Centre's internal policy, the *Use of Physical Force Procedure*, dated 10 December 2018 ('Use of Force Procedure').<sup>2054</sup> Consistent with the Youth Justice Act, the Use of Force Procedure prohibits the use of force other than in specific, limited situations. It states:

The use of physical force is a prohibited action, unless it is reasonable and necessary to prevent harm to a person or property. Where it is reasonable and necessary, the minimum amount of force must be used for the shortest time possible. The goal is to ensure the safety of all concerned and to help the young person regain control of their behaviour as quickly as possible.<sup>2055</sup>

The Use of Force Procedure provides that physical force may be allowed where it is reasonable and necessary to:

- conduct a search
- prevent a young person from injuring themselves or anyone else
- prevent a young person from damaging property
- ensure the security of the detention centre
- place a young person in isolation.<sup>2056</sup>

When there is a risk of a child or young person's behaviour requiring use of force, the Use of Force Procedure suggests a (non-exhaustive) list of strategies to reduce the chance of an incident occurring or escalating. This includes:

- using de-escalation strategies known to work with the young person
- talking to the young person in a calm and non-threatening way
- changing their routine
- changing their unit placement.<sup>2057</sup>

When force is required, staff must ensure that minimal force is used, as outlined in the *Minimising the Use of Physical Force and Restraint Practice Advice*.<sup>2058</sup> Staff must not use excessive force.<sup>2059</sup> 'Excessive force' is defined in the Use of Force Procedure as:

- more force than is needed or for longer than is needed
- any force or level of force continuing after the need for it has ended
- any force that might compromise the young person's breathing
- knowingly wrongfully using force.<sup>2060</sup>

The Use of Force Procedure explicitly states that disciplinary or criminal proceedings may follow an excessive use of force.<sup>2061</sup>

In this case study, we outline some accounts of the use of force at the Centre that are alleged to have taken place before the current Use of Force Procedure and Inspection Standards were adopted in 2018.

### 3 What we heard from victim-survivors about the use of force at Ashley Youth Detention Centre

This case study covers a series of concerning allegations regarding the use of force by some staff at Ashley Youth Detention Centre over many years. We acknowledge there have been and are staff at Ashley Youth Detention Centre who have sought to do their jobs lawfully and appropriately. References to ‘staff’ in this case study are not intended as a reference to all staff at the Centre, unless explicitly stated in a specific context.

As discussed in Case study 1, we heard evidence about some staff using force, violence and restraints against young people at Ashley Youth Detention Centre. While we do not comment on the veracity of each individual allegation outlined in victim-survivors’ accounts, we give weight to the commonality between accounts of the use of force at the Centre, including:

- force, restraints and physical violence being used to facilitate staff members’ sexual abuse of young people, or in connection with sexual abuse, including while conducting strip searches of the child. To avoid doubt, we consider strip searches that include touching of a child’s anus or genitals or penetration of a child’s anus or vagina to be child sexual abuse
- young people being restrained as part of isolation practices
- force, restraints and violence being used to punish young people for not following orders or for reporting abuse
- staff perpetrating violence against young people, and encouraging violence among young people, as a form of humiliation.

Ben (a pseudonym) was 11 years old when he was first detained at Ashley Youth Detention Centre in the early 2000s. He was in and out of the Centre many times throughout his childhood and teenage years.<sup>2062</sup> Ben recalled multiple instances where he said staff used force against him as punishment, reprisal or to manage his behaviour.<sup>2063</sup> He recounted that, on his first admission to the Centre, he reported abuse by older boys against him. He told us that, in response, staff restrained him, stripped him naked and verbally abused him.<sup>2064</sup>

Ben also recalled one occasion when, having tried to escape, he said he was ‘belted’, stripped naked, handcuffed behind his back, and had his feet cuffed together, before being placed in isolation.<sup>2065</sup> He told us he was left handcuffed and unable to move off the floor of the room where he was isolated for about five hours.<sup>2066</sup> He said he was then isolated for a further three weeks.<sup>2067</sup>

Ben told us that after multiple rapes and other instances of sexual abuse by staff during his time at the Centre, he became angrier and more aggressive.<sup>2068</sup> He said that as his behaviour escalated, he was often restrained by staff and targeted for further abuse.<sup>2069</sup> He said the amount of abuse perpetrated by staff against him was ‘a blur’ and led to an attempt to ‘[die by] suicide’.<sup>2070</sup> Ben recounted that following this suicide attempt, he was ‘flogged’ and put into isolation, where every couple of days, he would be ‘belted’ by staff.<sup>2071</sup> Ben stated that he twice suffered broken bones because of physical abuse by staff members.<sup>2072</sup>

Ben told us that some of the Centre staff did not have the skills to effectively manage the aggression and violence some young people displayed.<sup>2073</sup> He said maintenance staff at the Centre were sometimes called in to resolve incidents and to restrain young people.<sup>2074</sup> Ben said staff normalised violence and abuse against young people, and that on ‘countless occasions’ he witnessed new staff being ridiculed by long-term staff because they did not join in on restraining young people.<sup>2075</sup>

Simon (a pseudonym) was 10 years old when he was first admitted to Ashley Youth Detention Centre in the early 2000s.<sup>2076</sup> Simon recalled staff using force when carrying out strip searches. He recounted how staff told him they would need to hold him down during a strip search.<sup>2077</sup> When Simon refused and asked staff to perform a ‘normal’ search instead, three staff members wrestled him to the ground and spread his buttocks.<sup>2078</sup>

Simon also told us he was often physically abused by Centre staff for minor transgressions, such as refusing to go back to his room.<sup>2079</sup> He said that he and other young people would be ‘smashed up’ by staff for not going to bed on time, or ‘slipping up [and] doing something simple like a kid does’.<sup>2080</sup> He recalled that staff regularly left him with bruises and grazes.<sup>2081</sup>

Simon told us he generally did not complain about poor treatment while he was at the Centre, because he was afraid that staff might physically abuse him if he did.<sup>2082</sup> We heard from other victim-survivors who were detained at the Centre at various times between the early 2000s and late 2010s that they were afraid of violent reprisals from staff members if they reported abuse.<sup>2083</sup>

Charlotte (a pseudonym) was 12 years old when she was first admitted to the Centre in the early 2000s.<sup>2084</sup> Like Ben, Charlotte recalled a violent episode following an instance of self-harm. She told us that when she self-harmed while in lockdown, a staff member entered her room and slammed her head against the bed base, saying she ‘needed a flogging’ and she was ‘making more paperwork’ for the staff.<sup>2085</sup>

Fred (a pseudonym), who was detained at the Centre in the mid-2000s, described often being restrained by staff while they were strip searching him.<sup>2086</sup> Fred recalled that during one strip search, three or four staff held him down and put their knees on him.<sup>2087</sup>



Fred said that most of the time he was at Ashley Youth Detention Centre during the mid-2000s he felt ‘rough housed’ by staff, never knowing when they were going to ‘lash out’.<sup>2088</sup> Fred told us staff at the Centre would hit him on the back of his head, push him and jump on him.<sup>2089</sup> He recalled that when some young people from his activity group escaped from the Centre, staff handcuffed him and screamed at him to ‘interrogate’ him for information about the other boys’ whereabouts.<sup>2090</sup> Fred also told us he witnessed a staff member dragging a young girl naked from the shower by her hair, before handcuffing her.<sup>2091</sup> Fred said staff generally treated the young people in the Centre roughly, including the youngest children.<sup>2092</sup>

Fred further described how staff treated violence between children and young people at the Centre ‘like a sport’, and often provoked young people into using violence against each other.<sup>2093</sup> Fred said the young people housed in the Franklin Unit called the unit the ‘gladiator pit’, because staff would stand back and observe violent fights, waiting until a fight was almost over before taking any action.<sup>2094</sup> Other victim-survivors detained at the Centre between the mid-2000s and late 2010s similarly recounted that some staff appeared to enjoy the violence that broke out between young people at the Centre.<sup>2095</sup>

Warren (a pseudonym), who was detained at the Centre in the mid-2000s, told us that some staff would ‘bring their bad mood to work’ and would be ‘physical’ with the children and young people whom they did not like.<sup>2096</sup> He recounted how staff would pin his arms behind his back, hurting his shoulders, and ‘ram [his] head into the walls’.<sup>2097</sup> He said the staff who he alleges abused him were consistently on the same shifts, working together.<sup>2098</sup>

Warren also reported that he was raped by staff on numerous occasions, while other staff members restrained him to facilitate the rapes.<sup>2099</sup> Otis (a pseudonym), who was at the Centre after Warren, similarly reported the use of violence by staff in the context of sexual abuse.<sup>2100</sup> He said that when the staff were not happy with the sexual acts he was forced to perform, including oral sex and rape, they became physically violent and threatened to take away his bedding or his canteen privileges.<sup>2101</sup> Otis also told us he was physically abused when he tried to yell out as he was being sexually abused.<sup>2102</sup>

Brett Robinson, who was detained at Ashley Youth Detention Centre during the late 2000s and early 2010s, similarly reported the use of force in the context of strip searching. Brett described an incident where, after he refused to remove his boxer shorts for a strip search, a staff member forcefully removed Brett’s shorts, then inserted his finger in Brett’s anus, saying, ‘Welcome to Ashley, boy, you do as you’re told’.<sup>2103</sup>

Brett also told us that staff would tell him to go to his cell and if he ‘didn’t move straight away they would manhandle you back to your cell for no good reason’.<sup>2104</sup> Brett reflected that if the staff members had just told him to hurry up, he would have gone.<sup>2105</sup>

Erin (a pseudonym), who was detained at the Centre in the mid-2010s, also told us she regularly witnessed staff members physically abusing other children and young people at the Centre.<sup>2106</sup> She recalled bad physical abuse, particularly against boys at the Centre, which sometimes resulted in broken arms and legs.<sup>2107</sup>

Max (a pseudonym), who was detained at the Centre in the late 2010s, told us he lashed out at a staff member during a strip search on him in an area of the Centre where there were no cameras.<sup>2108</sup> Max said the staff member punched him and reminded him that ‘there are no cameras up here’.<sup>2109</sup>

Max also alleged physical abuse by staff following a stand-off in the early 2020s, where he said he agreed with a staff member that he would drop his weapon if no one touched him and he was allowed to return to his room.<sup>2110</sup> Max recalled that when he dropped the weapon he was restrained by four staff members who ‘belt[ed] the absolute shit out of [me]’ before he was handcuffed and taken to his cell.<sup>2111</sup> Max told us his nose was bleeding, but he was left alone for an hour with no nurse sent to check on him. He had to resort to using toilet paper to stop the bleeding.<sup>2112</sup>

## 4 Reviews of use of force incidents (2016–19)

In July 2016, a series of incidents occurred at Ashley Youth Detention Centre during which young people were alleged to have damaged property at the Centre. While the incidents raised issues regarding worker safety, there were also concerns relating to how Centre staff used force and isolation to manage the incidents.<sup>2113</sup> We are aware of three reports prepared in response to these incidents—a Report to the Minister for Human Services (August 2016) and a Critical Incident Investigation Report (undated), both prepared by the Department, and a WorkSafe Tasmania report (February 2017).<sup>2114</sup>

Additional incidents involving the use of force occurred in November and December 2017, during which children and young people in detention were restrained by Centre staff. One young person was placed in isolation because of a perceived threat that he would assault other young people and staff.<sup>2115</sup> The Department initiated an internal review of the incidents in 2018.<sup>2116</sup> In 2019, the Ombudsman completed a preliminary inquiries report into one of the 2017 incidents in response to a complaint received from a young person in detention about the use of force by Centre staff.<sup>2117</sup>

The occurrence of these incidents in 2016 and 2017 suggested to us that, at least until recently, there was an ongoing culture of excessive, unreasonable or possibly illegal uses of force by some staff at the Centre. This reflects many of the experiences we were told of by witnesses who were detained at the Centre at various times since 2000, as described above.

Below, we briefly describe the nature of the incidents that occurred in 2016 and 2017. We then outline the major findings of each of the five reports prepared in response to the incidents by various arms of the State and oversight bodies, including the failings those reports identified and the recommendations they made.

## 4.1 2016 incidents of use of force and associated responses

### 4.1.1 Uses of force on 14 and 15 July 2016

On 14 and 15 July 2016, a series of incidents involving several young people in detention occurred at Ashley Youth Detention Centre ('the July 2016 incidents').<sup>2118</sup> We summarise below the aspects of the incidents that are relevant to our consideration of the uses of force. The summary is drawn from the subsequent reviews.

On the evening of 14 July, three young people detained at the Centre broke windows (including one window in the unit's common room) and armed themselves with pieces of broken glass.<sup>2119</sup> Tasmania Police attended the incident. Centre staff negotiated with the young people to disarm themselves.<sup>2120</sup> The incident eventually concluded. Centre staff (but not nurses) inspected the young people's hands for injuries, and the young people went to bed.<sup>2121</sup>

The following morning, 15 July 2016, two of the young people involved in the incident the previous evening entered the common room of the unit where they were housed. A maintenance worker had covered the room's broken window with cardboard.<sup>2122</sup> CCTV footage shows the young people appeared 'animated' or 'agitated'.<sup>2123</sup> An incident unfolded where a staff member appeared to attempt to block one young person gaining access or getting close to the broken window.<sup>2124</sup> One of the young people attempted to 'charge' at the staff member who was standing between him and the broken window.<sup>2125</sup> Two additional staff members stepped in, and the young person (who had 'charged' at the staff member) retreated to sit on a table tennis table in the common room.<sup>2126</sup> One of the three staff members (the 'third staff member') then approached the table tennis table, grabbed the young person by the shoulder, pulled him forward, swung him off the table and began pushing him by both shoulders towards his room.<sup>2127</sup> The third staff member and another staff member followed the young person into his room, before exiting about 15 to 30 seconds later.<sup>2128</sup> The next day, the young person alleged the third staff member had entered his room and punched him.<sup>2129</sup>

Soon after that young person was escorted to his room, another staff member put the other young person into a headlock and wrestled him to the ground.<sup>2130</sup> Three staff members pushed this young person down a hallway and into his room.<sup>2131</sup> The young person then tried to push the door open and one staff member 'kick[ed] him back in his room in ... the torso region'.<sup>2132</sup>

Later that day, at about 12.30 pm, another young person was kicking the broken window in the common room.<sup>2133</sup> A staff member engaged verbally with the young person and consequently the young person left the common room and entered the dining room.<sup>2134</sup> Two staff members, including the third staff member from the incident earlier that morning, then walked into the dining room, grabbed this young person, and escorted him to his room.<sup>2135</sup> When the young person reached the door of his room, he stopped, at which point the third staff member grabbed him, put him in ‘a full nelson hold’ and lifted him off the ground.<sup>2136</sup> The third staff member then carried the young person down the hallway and threw him into another room.<sup>2137</sup>

Three reports were prepared in response to the July 2016 incidents. We describe the findings of each report below.

#### **4.1.2 Report from Department to the Minister for Human Services (August 2016)**

The July 2016 incidents were reported to the Minister for Human Services on 18 July 2016.<sup>2138</sup> On 12 August 2016, following a detailed review of CCTV footage, the Minister was given a ‘full Information Brief’ on the matter.<sup>2139</sup>

The Minister sought a further detailed report.<sup>2140</sup> On 19 August 2016, the Department delivered a report to the Minister about the incidents.<sup>2141</sup> The report examined the possible use of excessive force, focusing on the actions of one particular staff member, against young people during the incidents.<sup>2142</sup>

The report noted that, while the specified staff member had been trained in non-violent crisis intervention, the restraints used were not consistent with the non-violence crisis intervention manual.<sup>2143</sup> The report noted that the use of force appeared to be ‘excessive to that which might be considered reasonable’, given the young person was seen calmly sitting before the use of force.<sup>2144</sup> The report stated that, during the incidents, de-escalation strategies did not appear to have been followed before staff resorted to force, and that the use of a ‘nelson’ hold by the third staff member on a young person, where force was applied to the young person’s neck and the young person was completely lifted off the ground, contradicted the type or use of authorised restraints in the Centre’s training and operating procedures.<sup>2145</sup> There is no sign in the report that its authors spoke to the young people involved in the incidents.<sup>2146</sup>

The report contained an action plan that stated the following should occur:

- proceed to act immediately in relation to the staff member, including:
  - starting Employment Direction No. 4—Suspension and Employment Direction No. 5—Breach of Code of Conduct processes
  - appointing an appropriate independent investigator
  - requesting the worker to be absent from the workplace on full pay<sup>2147</sup>

- develop a change management process, including allocating \$300,000 to appoint a senior change manager and develop a training package<sup>2148</sup>
- develop a WorkSafe Corrective Action Plan<sup>2149</sup>
- continue a review of priority practices and procedures<sup>2150</sup>
- develop a process to ensure the timely review of all critical incidents<sup>2151</sup>
- deliver risk assessment training in August 2016<sup>2152</sup>
- develop a proposal to strengthen the use of multidisciplinary teams to support a therapeutic-informed approach.<sup>2153</sup>

Secretary Pervan referred the conduct of the staff member in question to Tasmania Police, suspended the staff member on full pay as per Employment Direction No. 4, and started a formal process under Employment Direction No. 5, to run in parallel with the Tasmania Police investigation.<sup>2154</sup> Ultimately, the disciplinary process resulted in counselling, a reprimand and a temporary reassignment of duties.<sup>2155</sup> The police laid charges, however these were ultimately dismissed by the Magistrates Court, which found that the use of force was appropriate in the circumstances.<sup>2156</sup>

### 4.1.3 Critical Incident Investigation Report (undated)

Besides the report to the Minister for Human Services, the Department prepared a Critical Incident Investigation Report for WorkSafe Tasmania regarding the incidents on 14 and 15 July 2016.<sup>2157</sup>

The report categorised the events as five separate incidents occurring over the two-day period. It reviewed CCTV footage, policy and procedure documents, investigation reports and witness statements.<sup>2158</sup> The report noted difficulties due to:

- delays in receiving statements from staff
- inconsistencies between individual statements
- lack of CCTV coverage in certain areas in the Centre
- lack of audio accompanying the CCTV footage.<sup>2159</sup>

It appears the authors of the report did not speak to young people at the Centre.<sup>2160</sup>

The report made several findings, including:

- Despite statements from staff suggesting they feared for their safety and that the young people were acting in a ‘riotous manner’, no staff member activated their duress alarm or called a ‘code black’ as per the relevant Standard Operating Procedures.<sup>2161</sup>

- The actions of staff were ‘contrary to policy’ and identified an ‘organisational deficiency’.<sup>2162</sup>
- The actions of staff highlighted deficiencies in staff training and staff capability related to emergency response, risk reduction, de-escalation of violent behaviour, and sound decision making to support proactive risk awareness and safety.<sup>2163</sup>
- The CCTV footage did not appear to reveal de-escalation strategies.<sup>2164</sup>
- The restraint the staff members used did not comply with non-violent crisis intervention training.<sup>2165</sup>

#### 4.1.4 WorkSafe Tasmania Investigation Report (February 2017)

A WorkSafe Tasmania investigation, starting on 29 July 2016, was also conducted into the July 2016 incidents.<sup>2166</sup> The investigation report indicated that several factors led to significant deficiencies in Ashley Youth Detention Centre’s current safety management system. These factors were ‘training, consultation, resourcing, communication and, particularly, risk identification and effective management and control’.<sup>2167</sup> The investigation report noted ‘the use of isolation, the use of force, and ... a less institutionalised appearance within the facility’ were all factors that contributed to the July 2016 incidents.<sup>2168</sup> There is no sign the authors of the investigation report spoke to young people at the Centre.<sup>2169</sup>

WorkSafe Tasmania indicated that, while it recommended that no prosecution action be undertaken against any party, the Secretary of the Department was required to provide monthly status reports regarding the implementation of a remedial corrective action plan and a comprehensive safety management plan.<sup>2170</sup> The remedial corrective action plan included, as a high priority, to ‘[r]eview, evaluate and reinforce the agenc[y] culture. Ensuring compliance with the programme, policies and procedures (change management process identified and approved)’ within 12 months.<sup>2171</sup>

## 4.2 2017 incidents of use of force and associated responses

### 4.2.1 Use of force incidents occurring between November and December 2017

In 2017, three more incidents of possible excessive use of force occurred at Ashley Youth Detention Centre. We summarise these incidents here, drawing from the descriptions in the subsequent reviews.

In November 2017, an incident occurred where a young person assaulted an Ashley Youth Detention Centre staff member.<sup>2172</sup> The young person was ‘placed on his stomach’ on a couch and restrained, before being isolated.<sup>2173</sup>

In December 2017, an incident occurred involving a young person being ‘taken down’ by staff onto his back on a wooden bench, which he had jumped on after it appears he was informed that he was being moved to another unit.<sup>2174</sup> When the young person was on his back, a staff member ‘grasp[ed] [the young person] around the neck or head’, while four staff members restrained and handcuffed him.<sup>2175</sup> The young person was then dragged off the bench by the handcuffs, wrist locked and escorted to his room.<sup>2176</sup> CCTV footage showed the entire incident occurred within a minute of the staff members entering the TV room where the young person had been sitting.<sup>2177</sup> The young person was left handcuffed in his room for more than two hours. He complained that staff members used excessive force when they entered his room to remove the handcuffs.<sup>2178</sup>

During that December 2017 incident, another young person attempted to involve himself in the incident between the young person and four staff members.<sup>2179</sup> That other young person was ‘flung’ or ‘thrown’ from one staff member to another while the other young person was being restrained.<sup>2180</sup>

Later that month, a young person who appeared ‘angry’ was restrained on a wooden bench.<sup>2181</sup> CCTV footage showed that staff did not appear to engage non-violent crisis intervention processes before engaging in restraining the young person.<sup>2182</sup>

#### **4.2.2 Department’s Review of Incidents at Ashley Youth Detention Centre (2018)**

The incidents described above involving the use of force between November and December 2017 were reviewed by the then Director, Strategic Youth Services and Deputy Secretary, Children and Youth Services.<sup>2183</sup> It was agreed to establish an Incident Review Committee to review the incidents.<sup>2184</sup> The specific findings of the review regarding the use of force in relation to these incidents are unclear. The report, however, includes the following comments:

- In several instances there did not appear to be appropriate de-escalation techniques adopted before the restraints.<sup>2185</sup>
- There was a lack of clarity about policies and procedures regarding the supervision and movement of young people and the use of handcuffs, contributing to a lack of clarity about how to manage non-complying young people and how to safely escort them without causing injury.<sup>2186</sup>

The review did not speak to the young people involved in the use of force incidents.<sup>2187</sup>

The report included recommendations relevant to the use of force and staff practices, including:

- an incident with a use of force component must be downloaded from the CCTV footage in its original form and securely stored on a separate drive<sup>2188</sup>



- further training and information sessions were to be provided on isolation procedures and relevant delegations<sup>2189</sup>
- there should be greater clarity in the Centre’s Supervision and Movement of Young People Standard Operating Procedure on the required numbers of staff when moving compliant and non-compliant young people in detention<sup>2190</sup>
- Ashley Youth Detention Centre should be given its own training budget and:
  - a fixed-term position for a training manager should be created as a matter of urgency
  - the training manager should undertake a full audit of the training for each staff member
  - a permanent position for a training facilitator and assessor at the Centre should be created
  - the possibility of professional qualifications for all employees at the Centre should be explored<sup>2191</sup>
- onsite discussions should be held with management providing clear guidelines and clarifications about their roles and responsibilities regarding how employees are managed, including their ongoing professional development<sup>2192</sup>
- the Centre Manager must review every incident involving the use of force<sup>2193</sup>
- future legislative amendments should consider changes to the definition of the word isolation, noting that the term, as defined under the Youth Justice Act, was ‘not considered to be appropriate terminology for a youth detention centre’ and, if possible, ‘this should be replaced with language more appropriate to a therapeutic environment [the Centre] is striving to achieve’<sup>2194</sup>
- all staff are to be trained and undertake regular review training regarding verbal judo or similar de-escalation techniques and motivational interviewing techniques by suitable qualified persons<sup>2195</sup>
- a Use of Force Review Committee be established, and a percentage of all incidents be reviewed by the Committee. That this Committee should have a maximum of four people and include representatives from:
  - the Centre’s Training Manager or representative from Professional Services
  - Human Resources
  - Workplace Health and Safety
  - Quality Improvement and Workforce Development.<sup>2196</sup>

We understand the Human Resources, Workplace Health and Safety, and Quality Improvement and Workforce Development units were based in the Department and not Ashley Youth Detention Centre.

While it appears the review considered staff used inappropriate force, the Department decided that no action would be taken against the staff members involved in these incidents ‘due to gaps in training and procedures’ at the Centre.<sup>2197</sup>

#### **4.2.3 Ombudsman’s preliminary inquiries into the assessment of a use of force incident (December 2019)**

In January 2018, the Ombudsman received a complaint from a young person involved in one of the use of force incidents described above (involving the young person being ‘taken down’ by staff onto his back on a wooden bench, in December 2017).<sup>2198</sup> After the Department completed its review (described above), the Ombudsman’s office conducted a preliminary investigation of the specific incident relating to the complaint.<sup>2199</sup> This included considering the Department’s 2018 internal review.<sup>2200</sup> In December 2019, Ombudsman Richard Connock provided a preliminary inquiries report to Secretary Pervan.<sup>2201</sup>

In his report to the Secretary, the Ombudsman questioned the quality and thoroughness of the Department’s 2018 internal review (referred to above), describing it as ‘perfunctory’.<sup>2202</sup> Among other criticisms of the internal review, the Ombudsman stated the Department had failed to gather basic evidence to inform its assessment of the use of force against the young person who had complained to him, including:

- speaking to that young person about his version of events
- detailing any injuries the young person may have suffered
- reviewing what training on the use of force had been provided to staff at Ashley Youth Detention Centre.<sup>2203</sup>

The Ombudsman also noted the internal review had not included an assessment of whether the use of force was excessive against criteria in the Youth Justice Act relevant to what constitutes ‘reasonable force’.<sup>2204</sup>

The Ombudsman further noted in his report to the Secretary that the Department had been aware for some time there were gaps in the training of staff members at the Centre in relation to the use of force.<sup>2205</sup> The Ombudsman emphasised that an independent review of Ashley Youth Detention Centre, undertaken in 2015 (refer to Chapter 10), had identified that ‘[a] number of people who are involved in the training of Youth Workers expressed concerns at Youth Workers preferring to use physical means of dealing with young people rather than the de-escalation techniques emphasised in the training’.<sup>2206</sup>

The Ombudsman also emphasised that documentation relevant to a therapeutic change program that Ashley Youth Detention Centre had adopted before 2016, known as the 'Ashley+ Approach', had included significant investment in training, but that such training was not working. He quoted the Ashley+ Approach:

In December 2016 there was a majority of Youth Workers and staff [at Ashley Youth Detention Centre] with 10+ years experience in the Centre. The majority of these staff were originally trained for operating in a corrections rather than therapeutic environment. This training and the transition over recent years from a corrections focus to a rehabilitation and treatment focus are often at odds and despite significant investment in training some staff continue to operate from a corrections philosophy.<sup>2207</sup>

We are particularly concerned by the observations of the Ombudsman that:

Rather than supporting the Department's position that there are gaps in training, the reports appear to be demonstrating that there has been training provided but that there is an underlying cultural issue affecting its adoption.<sup>2208</sup>

The Ombudsman highlighted several similarities between the use of force incident in December 2017 and the earlier use of force incident that occurred in July 2016. According to the Ombudsman, these similarities included:

- de-escalation attempts appear to be limited
- the use of force was questionable
- there were no obvious immediate threats to the staff involved.<sup>2209</sup>

The Ombudsman questioned why the Department had not sought advice about whether the use of force in December 2017 amounted to an offence, considering that the use of force during the July 2016 incidents had been referred to Tasmania Police.<sup>2210</sup> The Ombudsman said it became apparent to him, when following up the December 2017 incident, that 'an unwritten reason for not pursuing any formal action in this case was due to concerns about already low staff morale following the prosecution in 2016'.<sup>2211</sup> The Ombudsman characterised this rationale as 'concerning', considering that '[t]he paramount consideration for the Department should be the safety and care of the vulnerable children in its care'.<sup>2212</sup>

At the end of his report to Secretary Pervan, the Ombudsman suggested the Department implement a formal process to ensure greater oversight of the use of force by Centre staff, namely that the Ombudsman's office be notified of all future use-of-force incidents at the Centre.<sup>2213</sup>

## 4.3 Systems observations

During 2016 and 2017, there appear to have been multiple instances of the inappropriate use of force at Ashley Youth Detention Centre. While one incident was raised with police, we remain unclear why others were not, despite the Department being aware of these incidents. We hold serious concerns regarding the Ombudsman's view that the Department appears to have placed undue emphasis on low staff morale as a reason to not take proportionate action, particularly in relation to the December 2017 incident. Staff morale should not be given priority over the safety of vulnerable children. We are also very concerned by the reliance in multiple reviews on additional staff training and policy clarification as the solution to addressing excessive use of force, particularly considering evidence that:

- training had been provided
- the conduct was inconsistent with existing policies on use of force
- there appeared to be cultural resistance to the adoption of the practices recommended by the training.

### **Finding—The excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately**

We find that, during the period under examination by our Commission of Inquiry (2000 to the early 2020s), some staff at the Centre have used excessive force as a method of humiliation, control and abuse of children and young people. While we have not tested the veracity of the individual allegations provided by children and young people previously detained in the Centre, we note patterns in the descriptions of the use of force from the early 2000s to the early 2020s. There were similarities between the type and circumstances of the violence across the allegations. Witnesses described force being used as punishment, and the accounts, viewed as a whole, suggested a pattern of some staff using force instead of de-escalation techniques to manage young people's behaviour. Most, if not all, of the accounts we heard describe an excessive, unreasonable or likely illegal use of force by some staff at the Centre. We heard this force was sometimes used to facilitate child sexual abuse, including through strip searching.

The series of incidents of inappropriate use of force during 2016–17, documented by the Department and other arms of the State, echoed these accounts. The various reviews identified:

- the use of force other than as a last resort
- little or no use of de-escalation attempts
- the use of force when there were no obvious threats to staff or others
- use of force that was injurious or dangerous and outside accepted practice for when force is required.

The Department and the Tasmanian Government were aware of some of these instances of force. Except for the one referral to police and a disciplinary process, we are not convinced there was an adequate response from the Department from 2016 to 2017. We are concerned by an apparent lack of disciplinary response in some instances and little evidence of supports provided to the children and young people involved. We are also concerned that instances of excessive use of force may not have been consistently reported to authorities outside the Centre.

We are particularly concerned that ‘gaps in training’ were accepted as an excuse for excessive use of force by staff members at the Centre. We share the views of the Ombudsman when he said the problem is more likely an ‘underlying cultural issue’ affecting the adoption of training. The Department should have a clear policy on the appropriateness of providing training, counselling or direction to Centre staff members who have repeatedly demonstrated resistance to change.

### **Finding—The Department’s responses to excessive use of force do not represent a child-centred approach in line with the United Nations Convention on the Rights of the Child**

We note with concern that, while the Department and Tasmanian Government were aware of excessive use of force against children and young people in detention, there are no records that suggest:

- an open disclosure process was initiated, acknowledging that the use of force was inappropriate and offering an apology—an open disclosure approach to abuses by staff of children in detention is essential to enabling a culture of disclosure and to children believing their right to be free from violence and abuse will be upheld

- young people’s views and experiences were always sought in the investigations and reviews into what happened to them, or to inform the policies and reforms designed to enhance their care—the United Nations Convention on the Rights of the Child and the Child and Youth Safe Standards are clear on the critical importance of children taking part in decisions that affect them
- physical and psychological impacts of excessive use of force were adequately assessed and responded to.

Finally, concerns regarding staff morale should not be prioritised above the best interests of children.

# Case study 5: A response to staff concerns about Ashley Youth Detention Centre

## 1 Overview

Alysha (a pseudonym) began her role as a Clinical Practice Consultant at Ashley Youth Detention Centre in October 2019.<sup>2214</sup> Her duties comprised professional consultation and support to the Centre's staff, including on interventions and complex cases, and promoting the application of a therapeutic approach in youth detention.<sup>2215</sup>

Alysha told us about the difficulties she experienced at the Centre. She described a 'toxic, misogynistic and dangerous' internal culture that she felt affected her and the young people at the Centre.<sup>2216</sup> Alysha said she witnessed or learned of conduct at the Centre that harmed young people or put them at risk of harm, including sexual abuse. She also said she experienced sexual harassment, bullying and discrimination from other Centre staff.

Alysha told us how she attempted to raise her concerns about the Centre's culture with members of Centre management and Department officials who oversaw the Centre's operation.<sup>2217</sup> In particular, between December 2019 and January 2020, Alysha told us she reported a series of allegations regarding the treatment of young people at the Centre and agitated for an appropriate response. Those allegations included:

- an incident of historical sexual abuse against a young person at the Centre by a serving Centre staff member (who we refer to as Lester (a pseudonym))<sup>2218</sup>
- incidents of harmful sexual behaviours between young people at the Centre
- instances of staff misconduct, including:
  - unlawful strip search and isolation practices
  - using older children in the Centre who displayed harmful sexual behaviours 'as a means of controlling' younger children
  - placing younger children in detention with older children with what Alysha said was the 'express intention' of exposing younger children to sexual abuse.<sup>2219</sup>

The above allegations, and the Department's substantive responses to them, are discussed in Case studies 2, 3 and 7.



Alysha told us she also reported her experiences of sexual harassment, bullying and discrimination to Centre management and the Department. While Alysha acknowledged that some of this conduct occurred at the beginning of her tenure at the Centre, she felt the sexual harassment and bullying she experienced ‘escalat[ed]’ during her time there.<sup>2220</sup>

Alysha said she considered the treatment she received at the Centre was in response to her ‘speaking up about improper practices and advocating for children who were at risk’.<sup>2221</sup> For example, she told us how bullying from at least one co-worker ‘gradually worsen[ed]’ as Alysha:

- attempted to supervise Operations staff (a practice within Alysha’s job description)
- recommended that matters were reported to police
- ‘advoca[ted] against a highly punitive approach towards the children’
- suggested therapeutic alternatives to proposed action by Centre staff.<sup>2222</sup>

Alysha took leave from her role in late April 2020 due to what she described as ‘safety concerns and stress’.<sup>2223</sup>

In 2021, Alysha raised matters concerning alleged workplace sexual harassment and bullying at the Centre directly with the then Premier, the Honourable Peter Gutwein MP.<sup>2224</sup>

On 10 September 2021, Premier Gutwein appointed Melanie Bartlett to undertake a review ‘of the responses to and processes conducted by the [Department] in relation to any complaint made by [Alysha] concerning workplace bullying, assault or sexual harassment’.<sup>2225</sup> The Department was not aware of Alysha’s meeting with the Premier and the contents of that discussion until after this time and did not prepare the terms of reference for Ms Bartlett’s report.

On 20 September 2021, Alysha made a formal complaint about a number of matters, including the way Michael Pervan, former Secretary of the Department, and Pamela Honan, Director, Strategic Youth Services, responded (or failed to respond) to the reports Alysha had made (and which Mr Pervan and Ms Honan either were, or should have been, aware of) regarding child sexual abuse, harmful sexual behaviours and staff misconduct at the Centre. Ultimately, Alysha’s specific complaints against Secretary Pervan and Ms Honan were dismissed. We refer to this complaint as ‘Alysha’s September 2021 complaint’. We discuss different aspects of Alysha’s complaint and the associated responses below.

We understand Alysha has now resigned from the State Service. The circumstances of Alysha’s leave of absence and resignation are beyond the scope of our Commission of Inquiry. However, Alysha’s September 2021 complaint raised serious questions about whether high-ranking Department officials had responded appropriately to the concerns she raised about the risks faced by young people detained at the Centre and the culture there, including risks of child sexual abuse.

As then Secretary of the Department, Secretary Pervan had the portfolio responsibility for the welfare of children detained at the Centre. That responsibility is recognised in the *Youth Justice Act 1997* ('Youth Justice Act'), under which the Secretary is designated as 'guardian' of children in detention.<sup>2226</sup> Specifically, the Youth Justice Act states that the Secretary is responsible for (among other things) the 'safe custody and wellbeing' of young people in detention.<sup>2227</sup> Similarly, Ms Honan described her role as Director as encompassing oversight of the 'safe and secure operations of' Ashley Youth Detention Centre.<sup>2228</sup> Such oversight roles are now embedded within the Department for Education, Children and Young People. These roles are critical parts of the departmental infrastructure that ensures the welfare of young people in detention, including protecting them from sexual abuse.

Accordingly, Alysha's September 2021 complaint raised serious concerns about whether the Department acted appropriately to ensure the safety of young people at the Centre. More broadly, her complaints invited interrogation of the effectiveness of the broader system within the Department to ensure such welfare. In this context, the way the State and Department responded to the complaints against Ms Honan and Secretary Pervan provides valuable insight into the State and Department's recent attitude and approach towards complaints about how reports of child sexual abuse and associated matters are managed at the Centre.

## 2 Complaints Alysha made against Ms Honan and Secretary Pervan

On 20 September 2021, Alysha's lawyer wrote to Paul Turner SC, Assistant Solicitor-General (Litigation), Department of Justice, setting out complaints Alysha made against Ms Honan and Secretary Pervan ('September 2021 Letter').<sup>2229</sup> Alysha made six complaints against Ms Honan. Alysha alleged that Ms Honan knew, or ought to have known, of the sexual harassment, bullying and discrimination Alysha suffered during her time at the Centre. Alysha also complained that Ms Honan failed to respond appropriately to Alysha's reports of such behaviours. Alysha also alleged that Ms Honan:

- discouraged Alysha from reporting allegations of Lester's serious sexual assault and/or rape of a young person at the Centre, and/or attempted to 'shut down' or 'frustrate' investigations of those allegations ('allegations of child sexual abuse by staff') (noting Alysha reported allegations about Lester in January 2020)
- discouraged Alysha from reporting harmful sexual behaviours between young people at the Centre, and attempted to 'shut down' and/or 'frustrate' investigations of those matters ('allegations of harmful sexual behaviour')

- knew of, and failed to address, staff misconduct and staff non-compliance with policies and laws, including isolation and strip searching practices, and the intentional exposure of young people to a risk of physical and sexual assault ('allegations of staff misconduct').<sup>2230</sup>

In relation to Secretary Pervan, Alysha alleged that he:

- mishandled Alysha's sexual harassment complaint against a Centre staff member
- knew, or ought to have reasonably known, of misconduct at the Centre regarding isolation and strip-searching practices, and the intentional exposure of young people to a risk of physical and sexual assault, and failed to respond appropriately.<sup>2231</sup>

Alysha claimed the above actions and failures amounted to breaches of the State Service Code of Conduct by Ms Honan and Secretary Pervan (refer to Chapter 20 for a discussion of the State Service Code of Conduct).<sup>2232</sup>

We discuss allegations regarding child sexual abuse by staff, harmful sexual behaviours by detainees, isolation, strip searching, the intentional exposure of young people to a risk of physical and sexual abuse and the Department's response to those allegations, in greater detail in Case studies 2, 3, 4 and 7. Notably, in Case study 7, we accept evidence that the Department failed to fully investigate Alysha's report regarding Lester at the time of her report in January 2020.

In this case study, we focus on the State and Department's response to Alysha's September 2021 complaint. We identified elements of the State and Department's management of Alysha's complaint that are concerning. These elements explain recent systemic deficiencies in attitudes and responses to allegations of failures by departmental officials in taking steps to protect children in detention from abuse.

### 3 Fragmentation of complaint

As described above, in September 2021, Alysha raised matters personally with the Premier. She also directed a letter to the Office of the Solicitor-General that shared her concerns about the Centre—concerns she had previously raised within the Centre or with Ms Honan.<sup>2233</sup> Several reviews and investigations were initiated in response to Alysha's various complaints about how the Department managed the concerns, including:

- independent preliminary assessment and investigation into Alysha's complaints against Secretary Pervan (started in September 2021 and completed in March 2022) ('Bowen Investigation')
- internal preliminary assessment of Alysha's complaints against Ms Honan (started in September 2021 and completed in June 2022) ('Preliminary Assessment')

- independent investigation into the State’s response to Alysha’s allegations of the workplace bullying, assault or sexual harassment she experienced at the Centre (started in September 2021 and finalised in October 2021) (‘Bartlett Review’).

These reviews and investigations were conducted by different people, and different areas of the State or Government were involved.

In this section, we briefly discuss the focus of each response to identify that:

- some matters of serious concern Alysha raised appear to never have been addressed
- taking this approach was a missed opportunity for the State and the Department to identify and address systemic matters.

In the remainder of this case study, we focus on problems with the Preliminary Assessment of Alysha’s complaints against Ms Honan.

### 3.1 Bowen Investigation

In September 2021, an independent investigator, Peter Bowen, commenced an investigation into the complaints against Secretary Pervan. We understand this Investigation was initiated by the then Premier, the Honourable Peter Gutwein MP.

Mr Bowen conducted an initial review of Alysha’s complaints against Secretary Pervan to determine whether there were reasonable grounds to believe Secretary Pervan had breached the State Service Code of Conduct.<sup>2234</sup> That initial review concluded that there were reasonable grounds for such a belief in relation to some complaints.<sup>2235</sup> As a result, Mr Bowen carried out a more thorough investigation of those complaints for which reasonable grounds existed.

The Bowen Investigation report was finalised on 30 March 2022.<sup>2236</sup> Ultimately, Mr Bowen dismissed the complaints or otherwise declined to investigate them on the basis that there were no reasonable grounds to believe that Secretary Pervan had breached the State Service Code of Conduct.<sup>2237</sup>

We acknowledge that the Bowen Investigation was conducted independently and do not comment on how it was conducted or its findings, aside from commenting on the decision to respond to it as a separate complaint.

## 3.2 Preliminary Assessment

On 28 September 2021, the Office of the Solicitor-General forwarded Alysha's complaints regarding Ms Honan to Mandy Clarke, Deputy Secretary, Children, Youth and Families, Department of Communities.<sup>2238</sup>

Ms Clarke then conducted a Preliminary Assessment of Alysha's complaints to determine whether there was reason to believe that Ms Honan had breached the State Service Code of Conduct.<sup>2239</sup> Kathy Baker, then Deputy Secretary, Corporate Services, Department of Communities, reviewed the Preliminary Assessment.<sup>2240</sup> As discussed further in this case study, we are unclear about who the final decision maker was.

The Preliminary Assessment did not deal with Alysha's allegations about workplace sexual harassment, bullying and discrimination. Instead, it deferred to the work of the Bartlett Review, stating:

The author is cognisant at the time of completing a preliminary assessment the Tasmanian Government commissioned an Independent Review which examined all matters concerning sexual harassment, workplace bullying and discrimination raised by the complainant.

The author is of the understanding the appointed Independent Reviewer met with the complainant to discuss the matters. The author made a decision that it was inappropriate for this preliminary assessment to make specific commentary of the matters given the Independent Review process will provide procedural fairness to the complainant to support a resolution to the matters.<sup>2241</sup>

Accordingly, the Preliminary Assessment conducted no analysis and reached no conclusions about Ms Honan's actions relating to Alysha's allegations of workplace sexual harassment, bullying and discrimination.

We are unaware of any steps the Department of Premier and Cabinet took to ensure the Department knew of the scope and limitations of the Bartlett Review. The evidence available to us suggests that, at least as late as the end of November 2021, the Bartlett Review report had not been provided to the Department.<sup>2242</sup> The wording of the Preliminary Assessment suggests the author was unclear as to the status of the Bartlett Review (let alone its scope of findings) at the time the Preliminary Assessment was finalised (June 2022).

The Preliminary Assessment concluded that the Department 'did not identify nor source any evidence which suggests that there is a reason to believe that Ms Honan has breached the [State Service Code of Conduct]' and no further action was taken.<sup>2243</sup> Ms Baker communicated the outcome of the Preliminary Assessment to Alysha on 30 June 2022, by letter attaching a copy of the Preliminary Assessment.<sup>2244</sup> This was some nine months after Alysha made her complaint.

### 3.3 Bartlett Review

As outlined in Section 1, on 10 September 2021, the Premier appointed Ms Bartlett to undertake a review ‘of the responses to and processes conducted by the [Department] in relation to any complaint made by [Alysha] concerning workplace bullying, assault or sexual harassment’.<sup>2245</sup> We understand the Bartlett Review was managed by the Department of Premier and Cabinet. The Bartlett Review was conducted in September and October 2021. The report was finalised on 22 October 2021.<sup>2246</sup> The scope of the Bartlett Review, as set out in its terms of reference, was narrow. It focused, as directed, on the Department’s response to allegations of workplace bullying, assault and sexual harassment the Department had previously received. Consistent with its terms of reference, the Bartlett Review excluded new allegations of bullying, assault and sexual harassment, which the Department had not previously received, including those contained in the letter from Alysha’s lawyer to the Office of the Solicitor-General. Matters not considered by the Bartlett Review included:

- Alysha’s allegations that she was bullied by other Centre staff as a response to ‘her needing to report matters that she had observed at [the Centre]’, because these complaints were not formalised, and available evidence showed Alysha considered the issues ‘to have been satisfactorily resolved’<sup>2247</sup>
- Alysha’s allegation regarding a Centre staff member swerving their car towards her, because she had not previously reported the matter to any Department staff member and had made no formal complaint on the matter previously<sup>2248</sup>
- the Department’s response to Alysha’s complaints against Secretary Pervan and Ms Honan that were raised in September 2021, given the Department’s response was ongoing.<sup>2249</sup>

We note also that discrimination was not within the scope of the Bartlett Review (despite the Department’s incorrect belief, as set out above).<sup>2250</sup> The Bartlett Review found no deficiencies in the processes the Department used to resolve Alysha’s previous complaints, but commented on:

- the delays in the investigation and the Secretary’s decisions about the previous complaints
- how the outcome of the investigation was communicated to Alysha.<sup>2251</sup>

We do not discuss those findings here.

## 3.4 Our observations

The State and/or the Department separated Alysha's September 2021 complaint into three different investigations. We are concerned this fragmented approach obscured the totality of Alysha's concerns about child sexual abuse occurring at the Centre and ultimately undermined the effectiveness of the State and Department's response to the matters she raised. Overall, Alysha's September 2021 complaint about Ms Honan and Secretary Pervan stemmed from the same set of allegations, including her concerns about:

- the abuse of young people in detention
- a toxic workplace culture within the Centre that accepted bullying, harassment and discrimination of staff and tolerated (if not enabled) the abuse of young people in detention
- a departmental culture that minimised reports or complaints about such practices or actively sought to harm staff who made such reports or complaints.

The complaints against Secretary Pervan and Ms Honan were approached on an individual level as disciplinary matters and were divided between the Department of Premier and Cabinet and the then Department of Communities, respectively. Each disciplinary process focused on the activities or matters within the respective control of Secretary Pervan and Ms Honan to form a view about whether either official had engaged in misconduct, as Alysha alleged.

We acknowledge that Alysha's complaints about Secretary Pervan and Ms Honan were conveyed in individual disciplinary terms. Still, by dividing Alysha's complaints about Secretary Pervan and Ms Honan and focusing immediately on the disciplinary issues, the State lost an opportunity to see that the complaints potentially disclosed systemic problems or failings at a departmental (as opposed to an individual) level related to the care and protection of children in detention.

Our analysis of the Department's response to some of Alysha's allegations, including allegations of child sexual abuse by staff and harmful sexual behaviours in Case studies 2 and 7, highlights multiple systemic problems that could have been identified by an appropriate response to Alysha's complaints.

In addition, separating the complaint and the responses to it meant the State missed an opportunity to consider whether Alysha's alleged experiences of sexual harassment, bullying and discrimination were reprisals for her efforts to report child sexual abuse, harmful sexual behaviours and other misconduct at the Centre. The Bartlett Review's terms of reference meant that it focused on previous complaints about workplace sexual harassment, bullying and assault while the Preliminary Assessment excluded consideration of workplace matters because of the existence of the Bartlett Review and the incorrect belief that it would address all workplace bullying allegations.



Alysha's view was that the sustained and escalating sexual harassment, bullying and discrimination she experienced was a direct response to her 'speaking up'.<sup>2252</sup> We are not aware that any government department or official acknowledged or was tasked with considering any potential nexus between Alysha's attempts to highlight issues at the Centre and the alleged mistreatment she experienced. While we are not in a position to determine whether Alysha was targeted by staff for raising concerns about children and young people, we are concerned the fragmentation of Alysha's September 2021 complaint left a significant issue unaddressed and may dissuade those who seek to raise concerns about risks to young people in detention.

We are also concerned that a response that separates elements of a complaint means the complainant must engage with multiple investigations, which is onerous, and may, again, deter people from raising concerns.

We do not consider the failure of the State or Department to recognise the systemic issues in Alysha's September 2021 complaint is attributable to the manner or form in which Alysha expressed her concerns about Secretary Pervan and Ms Honan. It was not her role to guide the State or Department to understand or acknowledge systemic problems in the issues she raised. A complaint or concern must always be addressed for its substance, not its form. We also accept Alysha was only reacting to actions or inactions she was aware of. Her efforts highlight the difficulties associated with raising complaints of this nature.

We appreciate that Alysha's September 2021 complaint started disciplinary procedures that engaged important principles, such as privacy and procedural fairness, which may require complaints to be dealt with individually or compartmentalised. However, we do not consider that such procedures must necessarily occur at the expense of acknowledging that such complaints can provide valuable information about the appropriate operation of the Department as a whole. An alternative approach that involved the appointment of a single investigator to investigate the complaints against the two individuals and the Department as a whole would have reduced risks associated with fragmentation.

## 4 Preliminary Assessment

In the remainder of this case study, we consider how the State responded to the complaint about Ms Honan specifically and identify several problems regarding:

- how the Preliminary Assessment was allocated and managed
- delays in conducting the Preliminary Assessment
- the Preliminary Assessment becoming a quasi-investigation and containing many inaccuracies.

## 4.1 The process for allocating and managing the Preliminary Assessment

We were concerned that Ms Clarke and Ms Baker were inappropriately allocated the Preliminary Assessment as they had an actual, real or perceived conflict of interest in the substantive matters of the complaint. We were also concerned that there was no clear decision maker in this Preliminary Assessment. We set out our concerns below.

### 4.1.1 Conflicts of interest

As described earlier, Alysha's September 2021 complaint was directed to the Office of the Solicitor-General. Ms Clarke told us that on 28 September 2021, the Office of the Solicitor-General 'forwarded' Alysha's complaint to Ms Clarke by email.<sup>2253</sup> In her evidence at our hearings, Ms Clarke also referred to the complaint having been referred from the Office of the Solicitor-General to the Deputy Secretary.<sup>2254</sup> Ms Baker told us that the complaint was 'referr[ed]' from the Office of the Solicitor-General to Ms Clarke.<sup>2255</sup>

By the Office of the Solicitor-General 'providing' or forwarding' Alysha's complaint to Ms Clarke it is not clear whether:

- the Office was seeking to have Ms Clarke carry out a Preliminary Assessment
- Ms Clarke understood the referring or forwarding of the complaint as a direction to do so
- the Office was simply forwarding the relevant portion of the complaint to Ms Clarke as the manager to whom Ms Honan reported and to determine herself how to respond.

We received no evidence that the Office of the Solicitor-General played a role in managing the response.

Both Ms Clarke and Ms Baker are listed as the 'decision-makers' on the Preliminary Assessment form, with Ms Clarke identified as the 'preliminary assessor' and Ms Baker identified as the 'reviewer'.<sup>2256</sup> Ms Clarke explained that the reason the matter was referred to her as Deputy Secretary was because Secretary Pervan had a conflict of interest in the matter (as Alysha had also made a complaint about Secretary Pervan).<sup>2257</sup> Ms Baker, in responding to a query about Ms Clarke's role in conducting the Preliminary Assessment, also noted Secretary Pervan's conflict of interest.<sup>2258</sup>

We commend the State's early recognition of Secretary Pervan's conflict and his consequent inability to take part in the Preliminary Assessment. We were concerned that Ms Clarke and Ms Baker were involved in carrying out the Preliminary Assessment. Ms Clarke and Ms Baker had been involved in the Department's response to some of the matters Alysha had initially reported to Ms Honan, both personally and as executive managers of their respective areas in the Department.

Ms Clarke and Ms Baker’s involvement in responding to some of the substantive matters in Alysha’s complaints, particularly relating to the allegations about child sexual abuse by staff and harmful sexual behaviours at the Centre, included:

- Ms Baker was notified of the allegations about child sexual abuse by staff on 10 January 2020, the day after Alysha raised this concern with Ms Honan.<sup>2259</sup>
- Ms Baker directed People and Culture to consider the matter in January 2020.<sup>2260</sup>
- Ms Baker understood that People and Culture had undertaken ‘extensive file searches’ shortly after Alysha’s report to determine whether information relating to the allegation was held on Lester’s file or there had been prior Abuse in State Care Program claims against Lester.<sup>2261</sup>
- Ms Clarke became aware of the allegations against Lester in September 2020 and was involved in the response from that point.<sup>2262</sup>
- Ms Baker and Ms Clarke attended key Strengthening Safeguards Working Group meetings in the Department to discuss how the Department managed allegations against Lester and other allegations of child sexual abuse against staff, at least up to Lester’s suspension from the State Service in November 2020.
- Ms Baker (and later, Ms Clarke, who was the Deputy Secretary with portfolio responsibility for child safety) knew that Lester continued to be on site at the Centre through much of 2020.
- As the Deputy Secretary, Corporate Services, Ms Baker was responsible for the People and Culture division. This division reported allegations of abuse against Lester to police in November 2020.

In Case study 7, we accept evidence that the Department initially failed to investigate Alysha’s report to Ms Honan about Lester. We base this conclusion on a statement Ms Clarke made in an internal email dated 21 September 2020, where she said in relation to an issues register recording matters relating to allegations of abuse at the Centre:

The Issues Register captures the issue that was raised by an AYDC employee [Alysha] which Pam [Honan] forwarded earlier today. This came to light during a discussion I had with Pam today and dates back to January 2020. It does not appear that any investigation has been undertaken on this matter, and I note [Lester] is also the alleged abuser.

I would suggest these are serious allegations relating to [Lester] ... A HR file review needs to occur, and the abuse in state care file may inform us as to whether a police report was made at the time.<sup>2263</sup>

We note that Ms Clarke was not aware of the allegations against Lester until around this time and the steps Ms Clarke took in September 2020 ultimately resulted in the Department assessing and responding to reports about Lester.

The Preliminary Assessment provided the following details about Ms Clarke's involvement in the Department's response to Alysha's report regarding harmful sexual behaviours at the Centre:

- On the day that Ms Honan received Alysha's report, 'Ms Honan discussed the matter with the Deputy Secretary Children, Youth & Families [Ms Clarke] which triggered the commissioning of a Serious Event Review of the incident'.<sup>2264</sup>
- The Serious Events Review Team terms of reference were 'developed and approved' by Ms Clarke (together with a member of the Serious Events Review Team).<sup>2265</sup>
- Ms Clarke received the Serious Events Review Team's report on 27 April 2020.<sup>2266</sup>

We were concerned by Ms Baker's proximity to the departmental response to Alysha's report about Lester, and Ms Clarke's proximity to the departmental response to Alysha's report about both Lester and incidents of harmful sexual behaviours at the Centre.

We understand the purpose of the Preliminary Assessment to have been to determine whether there was reason to believe Ms Honan had breached the State Service Code of Conduct. In doing so, Ms Clarke and Ms Baker were investigating the appropriateness of Ms Honan's conduct in responding to Alysha's reports for a disciplinary process. Their task was not, ostensibly, to inquire into the appropriateness of the Department's response to those reports more broadly, or the actions or inactions of other Department officials (including their own). However, we are concerned that, in investigating the appropriateness of Ms Honan's actions, Ms Clarke and Ms Baker were indirectly reflecting upon their own responses to some of the reports Alysha made.

We asked Secretary Pervan, Ms Baker and Ms Clarke whether they considered it was appropriate for Ms Clarke and Ms Baker to carry out the Preliminary Assessment, given their respective roles in responding to Alysha's reports.<sup>2267</sup>

Secretary Pervan said he considered their involvement in the Preliminary Assessment to be appropriate but provided no further comments or justification for his view.<sup>2268</sup>

In her written statement, Ms Clarke declined to comment on this request, deferring to the view of Secretary Pervan.<sup>2269</sup> When asked about the matter during our public hearings, she said:

... over the years I've certainly assessed individual directors or managers over time. I have no issue - I mean, I have professional working relationships with directors, I had a particular interest in this, I actually did want to assure myself, as I've said, so I felt I was best placed to. I was across detail, and so, perhaps you're saying, is there a perceived conflict of interest? I guess that then goes to who else would have been in a position to do that preliminary assessment because one of the reasons it was referred from the Office of the Solicitor-General to the Deputy Secretary was, Alysha was making a complaint about the Secretary as well, so there were different arrangements in place, which is why it ended up being the Deputy Secretary.<sup>2270</sup>

Ms Baker also acknowledged that Secretary Pervan was likely to have a view on the potential conflict, but commented in relation to Ms Clarke:

I note that the referral of the complaint was from the Office of the Solicitor General to Ms Clarke and given the allegations were against a Senior Executive Officer, it is my view that it was appropriate that Ms Clarke was the most suitable person to undertake the preliminary assessment. She had the requisite skills, knowledge and experience to undertake this in an objective and fair manner. I don't consider that because Ms Honan reported to Ms Clarke that it meant she could not complete the assessment.<sup>2271</sup>

We asked the State whether it had identified any actual, potential or perceived conflict of interest relating to the investigation, management or determination of Alysha's complaints against Ms Honan. In a response received from the Department for Education, Children and Young People, we were told that the State had not identified any such conflict of interest.<sup>2272</sup>

We are not convinced the process for referring the matter to Ms Clarke and Ms Baker adequately considered or reflected upon the extent to which Ms Baker and Ms Clarke may have each had a conflict of interest in this matter—that potential conflict being that in investigating the suitability of Ms Honan's actions, Ms Clarke and Ms Baker were indirectly reflecting upon their own responses to some of the reports Alysha made. Ms Baker and Ms Clarke have both expressed to us that they do not consider they had any conflict of interest. We consider it would have been preferable, subject to any overriding requirements in Ms Honan's instrument of employment, for the complaint against Ms Honan to have been outsourced to an independent assessor, as was done in relation to the complaint against Secretary Pervan.

### **Finding—The Department should not have conducted the Preliminary Assessment and this reflects systemic problems**

We were concerned by the lack of evidence provided to our Commission of Inquiry about the appropriate allocation of the Preliminary Assessment, including the extent to which the State considered the appropriateness of Ms Clarke and Ms Baker's involvement in the Preliminary Assessment.

Ms Clarke and Ms Baker were involved in processes that were under direct consideration in the Preliminary Assessment. These processes included initiating, conducting or directing the scope of investigations relating to Alysha's complaints regarding Lester and (in Ms Clarke's case) responding to allegations of harmful sexual behaviours at the Centre. Each had a personal interest in demonstrating the suitability of Ms Honan's (and, by extension, theirs and the Department's) response to Alysha's reports. In that context, we consider there are serious

questions about whether Ms Clarke and Ms Baker had actual, potential or perceived conflicts of interest such that they should not have been allocated or conducted the Preliminary Assessment.

As described above, Ms Clarke contended that the question of her and Ms Baker's conflicts 'goes to who else would have been in a position' to conduct the Preliminary Assessment. We disagree that no other person was suitable to undertake the Preliminary Assessment. We were not convinced that an independent reviewer, such as a Secretary from another Department or the Head of the State Service, could not have been appointed to undertake this task. More objective reviewers may have been better placed to identify systemic concerns and to divert them for consideration appropriately (beyond the narrow forum of the disciplinary action against Ms Honan).

These problems reflect systemic matters we have observed elsewhere. The absence of clear direction and policy guidance relating to preliminary assessments raises the risk of conflicts of interest not being recognised and understood. We are not confident the process for initiating and conducting a preliminary assessment was well understood because:

- the complaint was forwarded to Ms Clarke by the Office of the Solicitor-General
- Ms Clarke and Ms Baker were allowed to conduct the Preliminary Assessment without apparent acknowledgment or management of their actual, potential or perceived conflicts of interest.

We do not consider the Preliminary Assessment should have been structured in this way.

We consider it is a critical systemic issue that the Employment Direction No. 5—Breach of Code of Conduct process does not provide for situations where there is or may be a conflict of interest, as there was in this instance.

Poor or unclear processes for complaints, including the Preliminary Assessment process, can undermine people's confidence in making complaints about child sexual abuse or responses to it.

### 4.1.2 Lack of a clear decision maker

We were unable to determine who was the decision maker regarding the Preliminary Assessment.

Ms Clarke and Ms Baker are listed as the ‘decision-makers’ on the Preliminary Assessment form.<sup>2273</sup> The Preliminary Assessment form does not state that any other person played a role in managing, conducting or determining the outcome of the assessment.

Before our public hearings, Secretary Pervan, Ms Baker and Ms Clarke were asked several questions about the Preliminary Assessment.<sup>2274</sup> In response to some questions, Secretary Pervan responded:

... I was advised by Kathy Baker that a complaint had been received and due to potential conflict of interest, Kathy Baker and Mandy Clarke would manage it. As a result, I do not have any further information to give.<sup>2275</sup>

We understand that Secretary Pervan’s evidence is that he did not ‘manage’ the Preliminary Assessment and that Ms Baker and Ms Clarke managed it instead.

We also asked Ms Clarke questions about the Preliminary Assessment, including whether she was satisfied that the Preliminary Assessment was conducted adequately and was an accurate and complete document.<sup>2276</sup> Ms Clarke did not respond to this question, stating that ‘[a]s the decision maker [Secretary Pervan] is best placed to answer this question’.<sup>2277</sup> In her procedural fairness response, Ms Clarke told us Secretary Pervan was the decision maker. She told us that this is demonstrated by Secretary Pervan approving and signing a Minute regarding Alysha’s complaint on 30 June 2022.<sup>2278</sup>

We also received evidence that the Office of the Solicitor-General was provided the Preliminary Assessment, although we are unclear for what purpose.<sup>2279</sup> We outline the timing of their involvement in more detail below.

After the hearings, we asked the State to describe how it managed Alysha’s complaint against Ms Honan, including by identifying each person:

- responsible for investigating, managing and determining the complaint and its outcome, the period during which they held that responsibility and the extent of their responsibility
- who provided input into the investigation, management and determination of the complaint, the nature of any such input and how the input was provided.<sup>2280</sup>

In response, the Department for Education, Children and Young People confirmed Ms Clarke undertook the Preliminary Assessment, which Ms Baker then reviewed.<sup>2281</sup> This response aligns with our understanding of Ms Baker and Ms Clarke’s evidence, as well as the information presented in the Preliminary Assessment.<sup>2282</sup>



The Department also told us that Secretary Pervan ‘manage[d]’ Alysha’s complaint against Ms Honan.<sup>2283</sup> The Department did not explain the nature of that role. For example, we are unaware whether Secretary Pervan’s role involved all or any of the following:

- making a final decision on whether to start an investigation under Employment Direction No. 5 (that is, an investigation into a possible breach of the State Service Code of Conduct) based on Ms Clarke and Ms Baker’s assessment
- providing advice or guidance to Ms Clarke and Ms Baker about how to conduct the Preliminary Assessment
- only providing administrative oversight of Ms Baker and Ms Clarke as their line manager but otherwise not participating in the decision making.

The Department did not identify any staff member adopting the role of decision maker or making a determination or decision, although noted the list of people it identified was not exhaustive.<sup>2284</sup>

We do not consider Secretary Pervan played a decision-making role regarding the Preliminary Assessment. However, we remain unclear as to the extent of his ‘management’ role as suggested by the Department.

The lack of a clear decision maker is concerning. In the usual course of events, the purpose of a preliminary assessment is to assist the Secretary to reach a conclusion about whether reasonable grounds exist to begin an investigation under Employment Direction No. 5—Breach of Code of Conduct (refer to Chapter 20 for a discussion of disciplinary processes).

When asked about the disciplinary process in place at the time of the Preliminary Assessment, Ms Baker explained that an investigation would begin only if the ‘Secretary, Communities Tasmania form[ed] a reasonable belief that [the] code [may] have been breached’.<sup>2285</sup> The Acting Executive Director, People and Culture, similarly noted that the decision to begin an investigation relied on the Secretary’s view that reasonable grounds existed to believe that a breach of the State Service Code of Conduct may have occurred.<sup>2286</sup> It was explained that:

Essentially a preliminary assessment is the collection and organisation of relevant information that can be progressed to the Head of Agency [i.e., Secretary Pervan] to consider whether he can form a reason to believe a breach of the Code may have occurred.

...

[People and Culture], in conjunction with operational managers / directors, and relevant Deputy Secretaries, review the information as part of the preliminary assessment.

...

Usually, it is the Deputy Secretary Children Youth and Families who briefs the Head of Agency in relation to whether a [disciplinary] process should be commenced in relation to an AYDC Official.

At times, this may also be the Deputy Secretary Corporate Services.<sup>2287</sup>

Ms Baker told us that the Secretary of the former Department of Communities could not delegate the power to decide to commence an investigation under Employment Direction No. 5—Breach of Code of Conduct.<sup>2288</sup> Ms Baker told us that a delegation is not required to undertake a Preliminary Assessment.<sup>2289</sup> It is unclear who would have made a decision to take disciplinary action against Ms Honan had it been recommended by the Preliminary Assessment.

### **Finding—The State does not have a clear process for initiating a preliminary assessment when the Secretary has a conflict of interest, including identifying a suitable decision maker**

We were concerned by the lack of a clear decision maker for the Preliminary Assessment in the context of Secretary Pervan’s recognised conflict of interest.

Had the Preliminary Assessment recommended disciplinary action against Ms Honan, it is not clear who would have made the decision to take such action. We were particularly concerned that we received inconsistent evidence about the nature of the role of decision maker in a preliminary assessment.

We also remain confused by:

- the lack of clarity about Secretary Pervan’s role as manager
- the role of the Office of the Solicitor-General in forwarding Alysha’s complaint about Ms Honan and in receiving the Preliminary Assessment once it was complete.

## **4.2 Delay in finalising the Preliminary Assessment**

There was an unacceptable delay in responding to Alysha’s September 2021 complaint.

Alysha’s complaints regarding Ms Honan were sent to the Office of the Solicitor-General on 20 September 2021. The decision based on the Preliminary Assessment was not finalised and communicated to Alysha until 30 June 2022, some nine months later.<sup>2290</sup>

We have serious concerns about the substantial time taken to finalise the Preliminary Assessment, as the complaint included concerns about the handling of allegations of child sexual abuse by staff and harmful sexual behaviours. Such complaints must be addressed quickly to ensure any ongoing risk to children is addressed.

We understand the timeline for completion of the Preliminary Assessment was:

- The Office of the Solicitor-General forwarded Alysha’s complaints regarding Ms Honan to Ms Clarke on 28 September 2021.<sup>2291</sup>
- Ms Clarke sent her initial assessment to Ms Baker on or around 20 January 2022.<sup>2292</sup>
- Ms Baker completed her review of Ms Clarke’s initial assessment before 9 February 2022 (according to Ms Baker’s statement to our Inquiry) or on 28 March 2022 (according to the date noted in the Preliminary Assessment).<sup>2293</sup>
- On 28 March 2022, Ms Baker forwarded the Preliminary Assessment to the Office of the Solicitor-General.<sup>2294</sup>
- A meeting between the Office of the Solicitor-General and Ms Baker to discuss the Preliminary Assessment was scheduled for 24 February 2022, but abandoned following the announcement that day of the decision to abolish the Department.<sup>2295</sup>
- Ms Baker followed up with the Office of the Solicitor-General twice in late March 2022 and once in early June 2022.<sup>2296</sup>
- Ms Baker communicated the final Preliminary Assessment to Alysha on 30 June 2022.<sup>2297</sup>

We have not received any documents confirming when the Preliminary Assessment was forwarded to the Office of the Solicitor-General. Based on the above timeline Ms Baker presented to us, we understand the Preliminary Assessment was with the Office of the Solicitor-General for approximately four months before Ms Baker communicated it to Alysha on 30 June 2022.

The Department for Education, Children and Young People told us the former Department of Communities ‘did not pursue finalisation of correspondence’ with Alysha in relation to the Preliminary Assessment because Alysha obtained new legal representation after March 2022.<sup>2298</sup> We are unclear why a change in legal representation might delay communication of the outcome of the Preliminary Assessment.

As discussed in Chapter 20, the Integrity Commission publishes guidelines on the management of misconduct in the public sector. Relevantly, it provides the following guidance on the timeframes for conducting preliminary assessments and investigations:

- The initial handling of a complaint should take between three working days and one week.<sup>2299</sup>
- A preliminary assessment and decision on whether to investigate should take up to two weeks.<sup>2300</sup>
- A simple investigation should take up to three months. A more serious or complex investigation should take between three and 12 months (and ‘ideally’ no longer than six months).<sup>2301</sup>

- A decision in response to an investigation should take no longer than two months, depending on a range of factors.<sup>2302</sup>

As this is guidance only, the Department is not required to comply with these timeframes.

We asked Secretary Pervan, Ms Clarke and Ms Baker to comment on whether they considered it was standard or acceptable for the Preliminary Assessment to take nine months to complete.

Secretary Pervan responded:

It is not standard but not unusual in cases without a participating victim, no participating or direct witnesses and no documentary evidence in an investigative process limited by the powers available under the *State Service Act 2000*.<sup>2303</sup>

As described above, we were told Ms Clarke completed her task of conducting the initial assessment by around 20 January 2022, approximately four months after the Office of the Solicitor-General forwarded the complaint on to her.<sup>2304</sup> Ms Clarke ended her role as Deputy Secretary for Children, Youth and Families on 11 February 2022. She was not with the Department when the Preliminary Assessment was finalised.<sup>2305</sup> Of the delay in completing the Preliminary Assessment, Ms Clarke said:

The timeframe for completing the preliminary assessment in my view and by my standards was not acceptable.

I am extremely disappointed that the assessment took this length of time. I acknowledge [Alysha] had been out of the workplace for some time and did not have up to date information and the matters raised by [Alysha] were important and serious and a more timely response was warranted.

There were a number of contributing factors as to why I was unable to complete the assessment sooner. The closure of [Ashley Youth Detention Centre] announcement in late September did divert my attention to preparing Youth Justice Reform planning and documents.

This meant the assessment was completed out of hours which I acknowledge is not satisfactory.<sup>2306</sup>

Ms Baker also said that competing priorities contributed to the delay, stating:

... the volume of work that [Ms Clarke, then] Deputy Secretary, [Children, Youth and Families] was undertaking at the time was significant. I consider the load on that role to be unsustainable. The nature of my own role often required work to be reprioritised, [one] such example which is relevant was needing to respond to the Government announcement to abolish the Department.<sup>2307</sup>

Ms Baker noted that while she ‘pursue[d] the matter for settlement with the [Office of the Solicitor-General] on multiple occasions’, she recognised that the Office had its own ‘competing priorities’.<sup>2308</sup>

Ms Baker shared Ms Clarke’s disappointment with the delay, acknowledging that the ‘timeframes are not ideal’ and ‘could have been improved’.<sup>2309</sup>

## **Finding—The delay in the Preliminary Assessment was not acceptable and risked exposing children to ongoing harm**

It concerns us that the Preliminary Assessment took significantly longer to finalise than the two-week timeframe recommended by the Integrity Commission. Indeed, the Preliminary Assessment even exceeded the recommended timeframe for a complex investigation of a breach of the State Service Code of Conduct. Delaying a response to a complaint about child sexual abuse or harmful sexual behaviours can result in a failure to address any ongoing harm to children, where the alleged abuser remains in their position. While we note that Lester had been suspended from November 2020, and so presented no immediate risk to child safety, there were still potential risks of harmful sexual behaviours being inadequately managed (which the Preliminary Assessment might have uncovered). In addition, unaddressed poor responses to allegations of abuse increase the risk of abuses going undetected.

As described above, Ms Honan's role is an important part of the Department's management structure that ensures the safety of children and young people in detention, including to protect them from sexual abuse. In our view, allegations that Ms Honan was not taking appropriate steps to respond to reports of harm to children and young people at the Centre should have attracted a swift response from the Department. Failing to do so may have placed children and young people at continued risk of harm.

This delay also had the unfortunate effect of drawing out the process and we are concerned about the degree to which this contributed to unnecessary stress on Alysha. We are unaware of attempts any person took to keep Alysha updated on the status of the Preliminary Assessment during this time.

We are also not aware that any person took steps to request the matter be allocated to another person; for example, an independent reviewer. We note the matter was with Ms Clarke for several months and she appeared to have submitted the initial assessment immediately before vacating her role.

It is concerning that, when asked whether the timeframe to complete the Preliminary Assessment was standard or acceptable, Secretary Pervan told us that it was 'not standard, but not unusual'.

We have given weight to the heavy workload under which both Ms Baker and Ms Clarke were operating and understand this likely contributed to the delay. We are concerned the role of Deputy Secretary, Children, Youth and Families was under-resourced and the scope of responsibility too broad, which may have contributed to the delay. This role had responsibility for Child Safety Services (including the Advice and Referral Line and out of home care) and Ashley Youth Detention Centre,

among other things (refer to Volume 4). This role carries significant responsibility for some of the State's most vulnerable children. The State must resource these functions adequately. For these reasons, we consider the delay to be reflective of broader systemic problems about the value placed on resourcing child safety.

### 4.3 Purpose and nature of the Preliminary Assessment

As discussed above and in more detail in Chapter 20, we understand the Department undertakes preliminary assessments to collate relevant information and determine whether there is reason to believe a breach of the State Service Code of Conduct may have occurred (being the threshold for the commencement of an investigation under Employment Direction No. 5).<sup>2310</sup> When describing to us how preliminary assessments are conducted, we were told: 'It is important to outline that preliminary work is not investigation work, it is a preliminary assessment, determining if, and how, to proceed'.<sup>2311</sup>

The Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector* states the purpose of a preliminary assessment is to 'quickly collect information so that someone in a position of authority can decide ... whether there is a reasonable suspicion of misconduct and ... the most appropriate way to deal with the matter'.<sup>2312</sup> As noted, the Integrity Commission recommends that preliminary assessments be conducted in three working days to verify basic factual information.<sup>2313</sup> It is not intended to become a quasi-investigation.

Based on this evidence, we would have expected the Preliminary Assessment to quickly ascertain whether Alysha had made complaints to Ms Honan and whether, on the face of it, there could have been serious questions about Ms Honan's response to these complaints.

In our view, features of the Preliminary Assessment, particularly in relation to the allegation about child sexual abuse by staff, were more closely aligned with a fully-fledged investigation into the reports that Alysha made, straying well beyond the narrow focus of a preliminary assessment. In particular:

- The Preliminary Assessment took a long time (refer to discussion above).
- Ms Clarke consulted a large volume of material as part of her assessment.<sup>2314</sup>
- The Preliminary Assessment addressed multiple matters that would appear more relevant to a full investigation into a possible breach of the Code of Conduct, including:
  - comparisons with other allegations made about Lester
  - weighing up of the veracity and consistency of Alysha's allegations.

Concerningly, the Preliminary Assessment appeared to consider the likelihood of the truth of the allegations against Lester and did not restrict itself to the appropriateness of responses to alleged child sexual abuse by a staff member.

In particular, the Preliminary Assessment compared the information received by Ms Honan from Alysha in January 2020 with other reports of Lester's behaviour received by the Department in August and November 2020.<sup>2315</sup>

Before our public hearings, we asked Secretary Pervan, Ms Baker and Ms Clarke each to explain the relevance of the discrepancies identified by the Preliminary Assessment between Alysha's report and information later received by the Department.

Secretary Pervan declined to respond to our request, deferring to Ms Baker and Ms Clarke's knowledge.<sup>2316</sup>

Ms Baker and Ms Clarke differed on the relevance of the analysis. Ms Baker responded:

The preliminary assessment sought to highlight the records that the Assessor (and in my case the Reviewer) analysed. It highlights the discrepancies between the initial report, what was reported via [Alysha's] representative at the time ... and what was reported in *The Nurse* podcast. It does highlight that the Department was dealing with varied information that needed to be worked through thoroughly in an attempt to verify what [Alysha] had reported.<sup>2317</sup>

We consider this comment indicates Ms Baker understood the purpose of the Preliminary Assessment to be about determining the truth of Alysha's report about Lester. In that context, discrepancies between reports of abuse may be relevant.

Conversely, Ms Clarke responded:

The preliminary assessment included information where discrepancies were identified and the witness statement [was] for [Alysha's] information only. The information had no relevance on the adequacy of Ms Honan's response. As the author I was very aware that I was not able to fully disclose a range of information to [Alysha]. The intention in sharing the discrepancies and information about the witness statement was an attempt to demonstrate to [Alysha] that the Department made every effort to identify all potential avenues of information that related to the matter she raised.

On reflection the intention of including this information may have been communicated differently to make this intention clear.<sup>2318</sup>

We understand Ms Clarke's response to suggest that the discrepancy between reports was not relevant to the Preliminary Assessment and that this detail was included for other, external reasons. Ms Clarke appears to have considered that the purpose of the Preliminary Assessment was to assess the adequacy of Ms Honan's response.

These responses are consistent with the varied evidence we received about the scope and purpose of the Preliminary Assessment more generally. In our public



hearings, Ms Clarke described the Preliminary Assessment of Alysha’s complaints in relation to Ms Honan as taking a form ‘similar to other preliminary assessments’.<sup>2319</sup> She said it did not involve ‘drilling into the actual specific detail of the actual individual complaints’.<sup>2320</sup> Rather, Ms Clarke said the Preliminary Assessment required ‘assessing the detail that was available that would form reasonable grounds for a breach of the Code [of Conduct]’.<sup>2321</sup> During our public hearings, Ms Baker described the Preliminary Assessment as ‘preliminarily assessing ... whether Ms Honan had responded appropriately or not appropriately to Alysha’s report’.<sup>2322</sup>

As described above, the purpose of the Preliminary Assessment was to ‘quickly collect information’ so the decision maker could determine whether there was reason to consider Ms Honan may have breached the State Service Code of Conduct, and to trigger a full investigation.<sup>2323</sup> Its purpose was not to determine the reliability or truth of the content of Alysha’s report or to assess the allegation against Lester.

### **Finding—The Preliminary Assessment was, at least in part, a quasi-investigation into the substantive reports made by Alysha (a pseudonym) about child sexual abuse by staff, due to a lack of clarity about preliminary assessments**

By engaging in this substantive assessment of the accuracy of Alysha’s report in relation to Lester in particular, it appears the Preliminary Assessment strayed into an investigation of Ms Honan’s response and the veracity of the allegations of child sexual abuse.

A full investigation of Alysha’s reports to Ms Honan was well beyond the purpose of the Preliminary Assessment—being to determine whether there were reasonable grounds to believe that Ms Honan may have breached the State Service Code of Conduct and so should have been further investigated. While an investigation of the accuracy of the allegations against Lester was an activity the Department should have undertaken, we disagree it was an appropriate feature of a preliminary assessment.

If the Preliminary Assessment had stuck to its task, there would have been an earlier opportunity to assess the need for an independent investigation into Ms Honan’s response to Alysha’s reports. Had this occurred, some inaccuracies in the investigation we highlight below may have been avoided.

Across many of our case studies, we have found that preliminary assessments stray into becoming quasi-investigations but without all the protections attracted by a formal investigation, including independence and procedural fairness. This is a systemic problem across many agencies.

## 4.4 Flaws in the Preliminary Assessment

We consider the Preliminary Assessment was better understood as a quasi-investigation. As a quasi-investigation, we had serious concerns about its accuracy, the thresholds applied in the Preliminary Assessment, and the impression the Preliminary Assessment gave about the adequacy of the Department’s response to the matters Alysha raised concerning child sexual abuse and harmful sexual behaviours at the Centre. We discuss our most critical concerns below.

### 4.4.1 Inappropriate threshold for responding to reports of abuse

Building upon the discrepancies it identified between Alysha’s report and later information received by the Department (described above), the Preliminary Assessment concluded Alysha’s report regarding Lester ‘[did] not provide information that would lead a reader to conclude without doubt a serious sexual assault [and/or] rape was perpetrated by [Lester]’, but contained ‘concerning information’ that ‘did warrant further assessment’.<sup>2324</sup>

We have had the benefit of reviewing Alysha’s initial email notification to Ms Honan and the Manager, Human Resources and Workplace Relations, of the former Department of Communities, sent on 9 January 2020.<sup>2325</sup> In that email, Alysha referred to an earlier conversation with the manager about the same issues raised, stating that she wished to ‘follow up [that] conversation’ with an email ‘for [her] own peace of mind’.<sup>2326</sup> Alysha then provided further details of the conversation she had with Ira (a pseudonym), a Centre staff member, during which he told Alysha about an event involving Lester several years earlier.<sup>2327</sup> Relevantly, Alysha wrote:

- ... [Ira] was working alongside [Lester]
- They were working in what was known as the ‘Secure unit’
- [Ira] described this in his story as a unit where only a few select staff were allowed to work, and that [it] was very secure, with a doorbell used if anyone needed to go into it
- He described walking into a room where a child ... was being “punished”
- [Lester] was standing over the child laughing
- The young boy was completely naked and on all fours (hands and knees) on the floor
- [Lester] was standing over him, behind him[.]<sup>2328</sup>

The manager acknowledged receipt of Alysha’s initial email in an email later the same afternoon, copying in Ms Honan.<sup>2329</sup> That evening, Alysha sent a further email to Ms Honan and the manager, in which she shared the following further details:

- This was the beginning of [Lester] being involved in office work due to him not being allowed to work with children.
- [Ira] said that judging by how the centre was run at this time, he is highly doubtful it went through HR.

...

- [Ira] said that [Lester] was often abusive towards the little ones, not so much the big kids.
- [Another Centre worker] recalled that he heard the same had happened though he did not know that someone had seen [Lester] in this position. He thought it was common knowledge that something of this sort had happened, when [Lester] was removed from working with the young people.
- The child was [aged under 15] or so and small at the time.<sup>2330</sup>

We note the Department subsequently obtained a witness statement from Ira in November 2020, some 10 months after Alysha's report.<sup>2331</sup>

We hold concerns about the Preliminary Assessment's conclusion that Alysha's report regarding Lester '[did] not provide information that would lead a reader to conclude without doubt a serious sexual assault [and/or] rape was perpetrated by [Lester]'.<sup>2332</sup>

This statement appeared to suggest the Department was applying a test that Alysha's information about Lester was required to lead Ms Honan to conclude, without a doubt, that misconduct had occurred and that such misconduct was a serious sexual assault or rape, before Ms Honan was required to respond. While not explicitly stated in the Preliminary Assessment, we are concerned the implication of this statement is that this is a threshold to meet for a report of child sexual abuse to result in action by the Department. We have been given no other reasonable explanation as to what else this language could mean.

We asked Secretary Pervan, Ms Clarke and Ms Baker to comment on whether such a test was applied in the Preliminary Assessment and, if so, from where that test was derived.

Secretary Pervan declined to respond to our request, stating that Ms Baker advised him that Ms Clarke and Ms Baker would manage this complaint.<sup>2333</sup>

Ms Baker's responses to our questions on multiple matters concerning the Preliminary Assessment are difficult to interpret as we cannot easily determine which of her answers responds to which question. On our best understanding, her response to our question about the application and origin of this test was more relevant to investigating the substance of the allegations against Lester than investigating Ms Honan's conduct:

We sought at the time [that Alysha] emailed [her complaint] ... to try and validate what information the Department may hold in relation to [Lester]. [Ira's] statement was key information for the Department to put the matter to the Secretary for his consideration and to suspend [Lester] as it was through [Ira's] firsthand account we were able to verify that [Lester] was in a room and with a naked child on hands and knees. From [Ira's] statement he said [Lester] was clothed and [Lester] was standing at the head of the young person. This was different to how [Alysha] described in her email (she advised [Lester] was standing behind the young person and standing over him).<sup>2334</sup>

Ms Clarke, in her written statement, said that as the author of the Preliminary Assessment she 'did not apply any test'.<sup>2335</sup> She continued:

In the context of [Alysha's] complaint relating to [Lester] the purpose of the preliminary assessment was to assess information to identify if there were reasonable grounds that suggested Ms Honan may have "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations".<sup>2336</sup>

Ms Honan also told us she did not personally apply a threshold to the allegation and she immediately passed on the allegation to Ms Baker.<sup>2337</sup>

We received no answer as to why the Preliminary Assessment referred to, and appeared to place weight on, the view that Alysha's report did not provide information that would 'lead a reader to conclude without doubt a serious sexual assault [and/or] rape' had occurred. Neither Secretary Pervan, Ms Clarke nor Ms Baker pointed us to any standard that required Alysha's report to meet such a high threshold.

In response to the suggestion that the Department applied any threshold, Ms Baker recently told us there are examples outside the matters that Alysha raised where there is evidence the Department acted.<sup>2338</sup> We were unable to seek details of these examples from Ms Baker before finalising our report.

We are concerned the conclusion in the Preliminary Assessment demonstrated a lack of appreciation for the seriousness of Alysha's report. Having considered the reports Alysha made, we consider the information she supplied indicated, at the very least, that serious misconduct of a sexual nature (or sexual abuse) may have occurred. This includes the allegations that:

- the child was naked, on the floor and alone in a room with Lester
- that room was in a building that had strictly limited staff access
- the incident was of such a nature that it appeared to result in Lester being moved to a role that prevented him working directly with children
- Ira had told Alysha that Lester was often abusive towards younger children.<sup>2339</sup>

The suggestion that Ms Honan needed to reach such a high threshold in relation to Alysha's report before acting is concerning for several reasons. In setting that higher threshold, the Preliminary Assessment creates the impression that the Department was seeking to justify Ms Honan's (and, by extension, the Department's) response to Alysha's report on the basis that Alysha did not clearly communicate an allegation of 'serious sexual assault' or rape. This view is problematic, as it minimises reports of child sexual abuse that do not involve rape or what it describes as 'serious sexual assault'.

In addition, the suggested threshold indicates Department staff are not sufficiently trained (or expected) to identify risks to children except where they are unambiguously stated in the most serious of terms. This is concerning given that many staff, including Ms Honan, Ms Clarke and Ms Baker, are mandatory reporters under the *Children, Young Persons and Their Families Act 1997*, under which they have an obligation to report where they believe or suspect on reasonable grounds or know that a child has been, or is being, abused or neglected.<sup>2340</sup>

We are concerned this threshold places a significant onus on the reporter to express their report in a way that will cause the Department to take notice. This is an inappropriate burden to place on reporters of child sexual abuse. Further, reporters may have many reasons not to provide certain details about offending or may simply not know enough to identify serious offending. In our view, it is more desirable to require the Department to be actively aware of indicators of sexual abuse and to respond accordingly.

Further, suggesting that only reports of rape or 'serious sexual assault' will be taken seriously may deter prospective reporters from reporting behaviours that appear to:

- place children at risk
- possibly constitute a boundary violation
- indicate grooming.

In addition, taking such an approach would render many children and young people's reports of abuse ineffective, as we know that they often disclose abuse incrementally. Their first report may not amount to rape or a serious sexual assault.

Lastly, requiring the person who receives a report of child sexual abuse to form a conclusion 'without doubt' about the veracity of the report circumvents the disciplinary and criminal justice processes established to undertake this task. Even a full misconduct investigation need only satisfy a balance of probabilities test.

#### 4.4.2 The Preliminary Assessment gives an inaccurate impression of the suitability of the Department’s response to Alysha’s reports

We were concerned by statements in the Preliminary Assessment that appeared to give an inaccurate impression of the suitability of the Department’s response to the matters Alysha reported to Ms Honan.

##### **Referrals to the police and Registrar of the Registration to Work with Vulnerable People Scheme**

In relation to allegations of child sexual abuse by staff, Alysha alleged Ms Honan ‘sought to instigate an internal investigation of the matter and discouraged reports being made to the “Strong Families Safe Kids” referral line and/or Tasmania Police’.<sup>2341</sup> Alysha also alleged Ms Honan ‘took unreasonable steps in “investigating” this matter prior to referring it to the appropriate agencies and/or took steps that reasonably frustrated the investigation’.<sup>2342</sup>

In response, the Preliminary Assessment relevantly stated:

- ‘No records were sourced during [the Preliminary Assessment] to indicate Ms Honan discouraged a report being made to Strong Families Safe Kids Referral Line and/or Tasmania Police’.<sup>2343</sup>
- ‘All information was provided to Tasmania Police and the Registrar, Registration to Work with Vulnerable People’.<sup>2344</sup>

In our view, these statements suggest that appropriately timed steps were taken to inform relevant agencies of the allegation against Lester. However, the Department reported the allegation against Lester to the police and the Registrar of the Registration to Work with Vulnerable People Scheme on 6 November 2020—approximately 10 months after Alysha’s initial report.<sup>2345</sup>

We consider the timing of these reports to external agencies to be material to the appropriateness of Ms Honan’s and the Department’s response. By failing to acknowledge the delay in reporting by the Department, the Preliminary Assessment failed to appropriately assess the reasons for that delay (and Ms Honan’s contribution to it, if any). Rather, the Preliminary Assessment appeared to simply accept the delay. This suggests the Department did not consider the reporting of the allegations against Lester to be urgent. Nor did it appear to consider the potential risk posed by Lester to other children with whom he had contact in his role at the Centre. This is indicated by the fact that the allegations against Lester are simply categorised in the Preliminary Assessment as ‘historical’.<sup>2346</sup>

## The Department's knowledge of other allegations made against Lester

In relation to allegations of child sexual abuse by staff, the Preliminary Assessment stated:

Following receipt of information from a third party the Department commenced a comprehensive review of the Tasmania Abuse in State Care Ex-Gratia Scheme records. The review found no application had been received in any one of the four Tasmanian Abuse in State care Ex-Gratia Scheme rounds in relation to the matter reported by the complainant or the third party.

...

At the time of completing this preliminary assessment the Department of Communities Tasmania has not received a request for information under the National Redress Scheme that relates to the matter raised by the complainant and/or is aware of any civil proceeding that may have relevance to the information provided by the complainant.<sup>2347</sup>

These statements are narrow and only confirm no claims or reports had been made that corroborate the specific allegation reported by Alysha in relation to Lester. While we accept the Preliminary Assessment, as a quasi-investigation, was primarily investigating Ms Honan's response to Alysha's allegations, we consider that, having determined to report upon Abuse in State Care Program and other allegations in the Preliminary Assessment, additional allegations against Lester are relevant to that response.

The Preliminary Assessment neglected to acknowledge various allegations of Lester's sexual abuse of young people (unrelated to the specific allegation Alysha reported in relation to Lester) which were known to either Ms Clarke or Ms Baker (or both) when the Preliminary Assessment was finalised. These included the following claims:

- Four claims made under the Abuse in State Care Program (including at least two claims made as early as 2008). Those four claims were known to the Strengthening Safeguards Working Group, of which Ms Baker and Ms Clarke were members, by October 2020.<sup>2348</sup>
- One other allegation of child sexual abuse of which Ms Clarke became aware in April 2021.<sup>2349</sup>

We asked Secretary Pervan, Ms Baker and Ms Clarke whether they considered the above statements in the Preliminary Assessment to be misleading.

Secretary Pervan said:

... while the Department was aware of other claimants and allegations against [Lester], we had not received [an allegation by the victim-survivor] arising from the incident described in [Alysha's] complaint.<sup>2350</sup>



Ms Baker and Ms Clarke responded similarly. They acknowledged other allegations concerning Lester but noted the lack of allegations about the specific incident Alysha reported.<sup>2351</sup> Ms Baker did, however, concede that '[w]ith the benefit of hindsight, [the statements] could have been better worded'.<sup>2352</sup>

Ms Clarke and Ms Baker emphasised they were concerned not to disclose personal information about Lester (including other allegations made against him) to Alysha through the Preliminary Assessment. During our public hearings, Ms Clarke told us she did not include this information in the Preliminary Assessment because Ms Clarke 'wasn't absolutely sure what [she] could disclose' to Alysha.<sup>2353</sup> Ms Baker made a similar comment, stating that:

... I don't think that [the statements that the Department had not received other reports of the allegation] was misleading. I think we could have better worded the disclosure in that report. Being mindful of what could be disclosed, but also bearing in mind that the matter that we were preliminarily assessing was whether Ms Honan had responded appropriately or not appropriately to Alysha's report. I don't think that it's misleading but I think that we could have possibly worded it better.<sup>2354</sup>

We consider there was good reason to reflect upon those other matters when conducting the Preliminary Assessment to assess Ms Honan's conduct. For example, the four claims made under the Abuse in State Care Program were not known to the Department until late 2020. Again, by not acknowledging these claims or the timing of their discovery, the Preliminary Assessment failed to consider their relevance to the complaint regarding Ms Honan's conduct (or others).

### **Reason for suspension from work**

The Preliminary Assessment stated the Department did not suspend Lester from work 'in relation to an allegation of serious sexual assault or rape as alleged by [Alysha] and in the Parliament in November 2020'.<sup>2355</sup>

We are unaware of what evidence was relied on to substantiate that statement in the Preliminary Assessment. However, the statement is inconsistent with the evidence we received. Specifically, we note:

- A Minute recommending the commencement of an investigation of Lester under Employment Direction No. 5 referred in detail to the allegations Alysha initially reported (and that Ira later recounted in his witness statement).<sup>2356</sup> The Minute also attached Alysha's initial email of 9 January 2020, which is described above.<sup>2357</sup> The Minute was cleared by Ms Baker on 7 November 2020 and approved by Secretary Pervan on 8 November 2020.<sup>2358</sup>
- In a letter to Lester notifying him of the commencement of an investigation under Employment Direction No. 5, the Secretary specifically referred to the allegations Alysha initially reported (and that Ira later recounted in his witness statement).<sup>2359</sup>

- In his written statement, Secretary Pervan confirmed the basis for his decision is ‘recorded in the documentation for the [Employment Direction No. 5 decision]’.<sup>2360</sup> We understand this includes the Minute he approved on 8 November 2020 inviting Secretary Pervan’s approval to commence a formal investigation under Employment Direction No. 5.

We acknowledge the 8 November 2020 Minute also refers to claims made previously under the Abuse in State Care Program. However, in our view, the above documents indicate that Secretary Pervan’s decision to start the investigation process under Employment Direction No. 5 was predicated on Alysha’s report and Ira’s confirmation of the account in that report.

We were surprised by the Preliminary Assessment’s insistence that Alysha’s report did not contribute to the decision to suspend Lester, despite the above evidence. That insistence appeared to downplay the relevance of Alysha’s actions to the Department’s ultimate response, inviting a view that her information was of little consequence or importance and (accordingly) did not warrant a thorough response from Ms Honan or the Department.

#### **4.4.3 The Department’s view regarding the accuracy of the Preliminary Assessment**

We asked Secretary Pervan, Ms Clarke and Ms Baker whether they considered the Preliminary Assessment to be accurate and complete.

Secretary Pervan replied affirmatively but did not provide reasons for his view.<sup>2361</sup>

Ms Clarke would not express a view on the accuracy or completeness of the Preliminary Assessment in her written statement.<sup>2362</sup> She said that as ‘the decision maker [Secretary Pervan] is best placed to answer this question’.<sup>2363</sup>

Ms Baker did not respond to this question. However, Ms Baker commented that, in her view as reviewer, the Preliminary Assessment ‘was adequate’.<sup>2364</sup>

We do not agree the Preliminary Assessment into Alysha’s complaint about Ms Honan was accurate or complete.

## **Finding—The Preliminary Assessment gave a false impression of the adequacy of the Department’s response to reports made by Alysha about child sexual abuse by staff**

As described above, we consider the Preliminary Assessment was conducted as a quasi-investigation into the matters Alysha reported. In that context, we are concerned by several flaws in the investigation, including that it:

- adopted an inappropriate threshold for responding to child sexual abuse allegations
- was misleading in terms of the Department’s response to some of Alysha’s allegations, including in relation to:
  - referrals to the police and the Registrar of the Registration to Work with Vulnerable People Scheme in relation to Lester
  - the Department’s knowledge of other allegations made against Lester
  - the reasons for Lester’s suspension.

It is unacceptable that the Preliminary Assessment stated that referrals regarding Alysha’s report of Lester’s alleged behaviours had been made to the police and the Registrar of the Registration to Work with Vulnerable People Scheme but did not acknowledge the timing of those reports was many months after Alysha’s initial report to Ms Honan.

It is also unacceptable that the Preliminary Assessment narrowly stated that no Abuse in State Care Program claims or other allegations had been made in relation to the matter Alysha reported regarding Lester, while failing to acknowledge allegations relating to Lester (but not otherwise related to the specific allegations Alysha reported) known to Ms Baker and Ms Clarke by late 2020, and a further unrelated allegation known to Ms Clarke by April 2021.

We consider that without further clarification, these statements gave the false impression there were no other matters known to the Department relevant to the issues in question at the time of the Preliminary Assessment. This includes whether there was a risk that Lester posed a threat to children detained at the Centre.

It is also unacceptable that the Preliminary Assessment failed to acknowledge the view formed by Ms Clarke herself in September 2020 that, at that time, Alysha’s January 2020 report of Lester’s suspected abuse had not been investigated by the Department.

Together, the above statements in the Preliminary Assessment gave a misleading impression that the Department had responded in a timely and appropriate way to Alysha's reports. They had the effect of overstating the appropriateness of the Department's actions (beyond merely those of Ms Honan) and ultimately directed the Preliminary Assessment away from relevant lines of inquiry, including what steps Ms Honan or other Department staff should have taken to better respond to Alysha's concerns.

It is also unacceptable that the Preliminary Assessment minimised the relevance of Alysha's report in the decision to suspend Lester from work.

We do not accept Ms Baker and Ms Clarke's evidence that the content of the Preliminary Assessment was limited by what could be disclosed to Alysha, such that they needed to exclude relevant evidence. Disclosure to Alysha was not the purpose of the Preliminary Assessment and should not have guided the way it was undertaken, particularly if it contributed to incomplete or inaccurate findings.

## 5 System problems

The Preliminary Assessment was finalised in the weeks and months before our public hearings regarding Ashley Youth Detention Centre. It provides a very recent snapshot of the Department's attitudes and approaches to reports of child sexual abuse and those who make such reports.

We asked Secretary Pervan, Ms Baker and Ms Clarke to each comment on whether they considered the State's response in 2022 to Alysha's complaints about Ms Honan represented a significant current failure to respond to reports about the handling of allegations of child sexual abuse.

Secretary Pervan said:

I would respond by pointing out that both Ms Clarke and Ms Baker are highly experienced managerial professionals. While I was not involved in this process I am aware that the approach they took was meticulous and involved discussions with the Office of the Solicitor-General. [Alysha's] complaints were made to Ms Honan during a complex period of change with respect to the State's consideration and response to allegations of child sexual abuse raised through financial redress applications.<sup>2365</sup>

Ms Baker responded:

As the Reviewer of the Preliminary Assessment, I don't agree that this was a significant failure. The timeframes could have been improved, and I would also like to acknowledge [Alysha] bringing this matter to the [Department's] attention.<sup>2366</sup>

Ms Clarke replied:

As the Official that undertook the preliminary assessment I do not agree the Department's response in 2022 to the complaint raised by [Alysha] in relation to Ms Honan's response to her complaint represents a significant current failure to respond to complaints about the handling of allegations of child sexual abuse. In the context of [Alysha's] complaint against Ms Honan regarding [Lester] the purpose of the preliminary assessment was to assess the available information to identify if there were reasonable grounds that suggested Ms Honan may have "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations" as alleged by [Alysha]. At the time the preliminary assessment was unable to identify any information that suggested Ms Honan "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations".

We are not convinced by these responses.

In our view, the responses to Alysha's September 2021 complaint indicate the following themes and attitudes in the Department's handling of reports of child sexual abuse and related matters:

- There was a culture within the former Department of Communities that failed to understand the behaviours that amount to child sexual abuse, considering only reports of rape or serious sexual assault would attract a thorough and timely response and applying a criminal standard of proof for disciplinary processes.
- Matters of relevance to child safety did not always attract urgent responses, and lengthy delays in investigating those matters did not raise significant concerns among Department staff.
- The former Department of Communities relied heavily on reporters to provide the right information in the right order and form before considering allegations about possible child sexual abuse.<sup>2367</sup>
- Senior staff of the former Department of Communities did not identify actual, potential or perceived conflicts of interest in conducting a preliminary assessment.
- Matters raised in complaints were on occasion siloed at the expense of engaging with the intent of the complaint.
- There was a failure within the State to recognise that bullying, harassment or discriminatory behaviours can be inextricably linked to an official's reports of child sexual abuse and illustrate a culture that does not promote or value child safety.
- There was a failure within the State to recognise that complaints against individuals can represent systems' failures that require a broader lens and response.
- Preliminary assessments appear to be used sometimes as quasi-misconduct investigations while avoiding the requirements of those investigations.
- There is no clear process for determining a decision maker for a preliminary assessment when the Secretary has a conflict of interest.

# Case study 6: A complaint by Max (a pseudonym)

## 1 Introduction

In Case study 1, we outlined the experiences of Max (a pseudonym), who was first detained at Ashley Youth Detention Centre in the late 2010s.<sup>2368</sup> In addition to Max's general experiences at the Centre, we have prepared an additional case example outlining an allegation that Max made during our Commission of Inquiry and how the Centre and senior management in the Department responded to that allegation.

Max's allegation was that a person in a managerial role ('the manager') at Ashley Youth Detention Centre offered him incentives to not meet with or complain to our Commission of Inquiry about his treatment at the Centre. This is a very serious allegation. Recognising the significance of this matter and the fact that there were differing accounts of what occurred, we have outlined the accounts of the different people involved in this allegation, which includes Max's account, as well as evidence from Ashley Youth Detention Centre's management and the Commissioner for Children and Young People.

In line with our practice of not proactively seeking out victim-survivors and other vulnerable people who had not voluntarily engaged with or provided information to our Commission of Inquiry, we did not contact another detainee who was said to have been a witness to the conversation between Max and the manager, and we did not rely on any evidence relating to this person.

We discovered the relevance of some witnesses to this matter late in our Inquiry, after our public hearings, when we received written notes from the Commissioner for Children and Young People. The timing of this discovery limited our ability to seek statements and test this evidence.

In the end, despite considering the matter carefully, we did not have enough evidence to draw a conclusion, on the balance of probabilities, and make a finding in relation to Max's allegation. Instead, our focus has been on how the Centre and the Department responded to that allegation.

We consider that the Department's approach to responding to Max's allegation was inappropriate and unacceptable given the nature and seriousness of the allegation. We consider the Centre's approach fell short of acceptable process. We consider the response to Max's allegation justifies a finding that the Centre and the Department did not appropriately respond to the allegation.

## 2 Max's recollection

Max spent time at Ashley Youth Detention Centre from 12 to 18 years of age.<sup>2369</sup> In Case study 1, we share some of Max's recollections of his experiences at the Centre.

Max told us that while detained at the Centre he engaged with the former Commissioner for Children and Young People 'to complain about what was happening at Ashley and the way the youth workers were treating me'.<sup>2370</sup> He said that this pattern of engagement continued when a new Commissioner, Leanne McLean, was appointed.<sup>2371</sup> Max told us that the way staff treated him changed once he started making complaints about his treatment:

After I started speaking to the Children's Commissioner the staff started treating me like shit. They stopped giving me food and drinks when I asked for them and would say 'you get what you get when you get it'. Before I started calling the Children's Commissioner they would just give things to me when I asked for it.<sup>2372</sup>

By his own account, Max was involved in some serious incidents at the Centre, including:

- Max was involved in a 'stand-off' with other detainees. Ashley Youth Detention Centre policy documents define a 'stand-off' as 'a situation in which neither of two opposing groups or forces will make a move until the other one does something, so nothing can happen until one of them gives way'.<sup>2373</sup> Max told us that staff sexually assaulted him during a strip search after this incident.<sup>2374</sup>
- Max consumed items from a package smuggled in by a fellow detainee, which Max told us led to him being physically restrained and invasively strip searched by staff while he resisted and attempted to hit a staff member.<sup>2375</sup>
- Max described an incident in which he attempted to hit a staff member and described other workers 'hitting, kicking and kneeling' him as a result.<sup>2376</sup>

Throughout his evidence and in his statement, Max acknowledged his own (sometimes destructive) behaviours and actions.

In late 2021, while detained at Ashley Youth Detention Centre, Max heard about our Commission of Inquiry and the planned closure of the Centre.<sup>2377</sup> Max told us: 'Once I saw that the Commission of Inquiry was starting up and Ashley was going to be shut down, I thought that was the best thing that could ever happen'.<sup>2378</sup>

At this same time, Max was complaining to Commissioner McLean about his treatment at Ashley Youth Detention Centre.<sup>2379</sup> He said that Commissioner McLean asked him whether he would like to speak to our Commission of Inquiry.<sup>2380</sup> Max recalled that he agreed to speak to us as 'an opportunity to tell my story'.<sup>2381</sup>



Max told us that the manager found out about his planned session with a Commissioner because it was organised by the Centre and Commissioner McLean.<sup>2382</sup> Max recalled:

About a week before I was due to meet the Commission of Inquiry, [the manager] came to see me and [another detainee] in [our unit]. He asked us ‘why are you having a meeting with the Commission?’ I said, ‘to tell them about everything that happens in this shit-hole’. He said ‘they don’t need to hear all that bullshit. They’ve got enough going on with fake allegations as it is’. He told us that if we said good things and don’t go telling lies he’d make it worth our while. He said that we would get to move to the step-down unit and that we would get to go off property at least twice a week. [The other detainee] and I both looked at each other and agreed to it as soon as he said it. It was a filthy [good] deal ...<sup>2383</sup>

Max told us during our public hearings:

[The manager], he pretty much tried to bribe me—well, not ‘pretty much’, he did; he said that he’d give us MA+ games ... he’d let the other person that done it as well with me go off-site ... he’d let us move to the new unit. Like, he’s giving us all these things, and straightaway we’re thinking, we can’t get any of them; yep, we’ll definitely do that.<sup>2384</sup>

On 10 November 2021, Max attended a session with a Commissioner held at Ashley Youth Detention Centre. Commissioner McLean also attended this session. Max later told our Commission of Inquiry that before this session he was unsure whether he should ‘tell the truth or act like it was all fine’.<sup>2385</sup> Max recalled that: ‘I went into the meeting and was asked what I wanted to speak about. I said I wanted to speak about how good the centre was. I said how great the centre was and how they help kids’.<sup>2386</sup> Max told us in a later statement to our Commission of Inquiry and during our public hearings that the information he gave in his session with a Commissioner was untrue. He said he ‘just went in there and said that, how good Ashley was, which was a load of shit’.<sup>2387</sup> He stated: ‘I fed them up on bullshit. I regret doing it now’.<sup>2388</sup>

Max told us that after his session with a Commissioner he spoke to the manager and told him that he ‘had said everything [at the Centre] was good’.<sup>2389</sup> Max recalled asking the manager when he would be moving to a new unit and when he would be able to go off-property.<sup>2390</sup> Max said that the manager told him he would have access to those privileges when his ‘behaviour change[d]’.<sup>2391</sup>

Max explained that when he heard this he felt the manager had ‘backed out’ of their deal.<sup>2392</sup> He felt that the manager ‘knew that we couldn’t take back what we said, so he just acted as if nothing happened, he acted like the conversation never happened’.<sup>2393</sup> Max told us he thought this was ‘bullshit’, so he ‘went off’ at the manager and a ‘code black’ was called.<sup>2394</sup> As discussed in Chapter 10, Ashley Youth Detention Centre staff call a code black as a request for immediate assistance.<sup>2395</sup>

After speaking to the manager, Max said that he phoned Commissioner McLean.<sup>2396</sup> He told her that the manager had ‘bribed me but then backed out of the deal’.<sup>2397</sup> Max said that Commissioner McLean asked ‘what the deal was’ and Max explained it to her.<sup>2398</sup> Max recalled Commissioner McLean telling him that she would call the manager to ‘find out what was going on’.<sup>2399</sup>

Max explained that after Commissioner McLean told him that the manager had denied his allegation, Max became angry and continued to act out:

[Commissioner McLean] later told me that she had spoken to [the manager] and that he denied it which he was obviously going to do. This really pissed me off so I continued with my behaviour.

At some point later I told [Commissioner McLean] that I probably wanted to talk to the Commission again.<sup>2400</sup>

When told by Counsel Assisting our Commission of Inquiry that the manager would give evidence that the conversation never happened, Max told us that his own account was ‘100 per cent truth’.<sup>2401</sup>

We are grateful to Max for speaking with us and recognise people who shared information with us often did so with a fear of perceived consequences or risk.

### 3 Commissioner McLean’s recollection

During our public hearings, we asked Commissioner McLean about her recollection of her engagement with Max in relation to his allegation that the manager ‘bribed’ him. Following the hearings, Commissioner McLean gave us a copy of the notes she compiled in advance of her appearance and to which she referred during her appearance.<sup>2402</sup> We acknowledge these notes were prepared for purposes other than providing a formal response to our Commission of Inquiry.

Commissioner McLean had advocated on behalf of Max a number of times during his previous detentions at Ashley Youth Detention Centre.<sup>2403</sup> She told us Max approached her on 29 October 2021 to ask for help to arrange a meeting with the Prime Minister or Premier ‘so that he could tell them the good things about Ashley’.<sup>2404</sup> She also told us that at the time Max wanted her help to access MA15+ video games while at the Centre. Commissioner McLean recalled that she suggested Max speak to us and arranged for him to attend a session with a Commissioner.<sup>2405</sup>

Commissioner McLean said she then began making arrangements for the session with a Commissioner.<sup>2406</sup>

Commissioner McLean told us that, on 4 November 2021, she also spoke to Max at length about his access to video games.

Commissioner McLean recalled receiving a phone call from Max on 9 November 2021.<sup>2407</sup> She said Max disclosed to her that the manager had visited him and, on Commissioner McLean’s recollection, alleged that he was offered an incentive to not speak to our Inquiry.<sup>2408</sup>

Commissioner McLean told us that Max’s comments concerned her.<sup>2409</sup> She told us that she spoke again to Max later the same day.<sup>2410</sup> Commissioner McLean also recalled speaking to the Centre’s psychologist on 9 November 2021, with Max’s consent.<sup>2411</sup> When they spoke, the psychologist confirmed to Commissioner McLean that she had spoken to Max the previous day (8 November 2021) about his complaint.<sup>2412</sup>

Commissioner McLean confirmed to us in hearings that she raised Max’s complaint with the Centre’s management after Max’s session with a Commissioner and never raised Max’s allegation directly with the manager.<sup>2413</sup>

On 10 November 2021, Commissioner McLean attended Max’s session with a Commissioner at Ashley Youth Detention Centre.

Commissioner McLean told us that Max contacted her again after his session with a Commissioner, on 12 November 2021.<sup>2414</sup> She recalled Max telling her that the manager had visited him after his evidence. During our hearings, Commissioner McLean described her conversation with Max:

Max contacted me to report that after the Commission of Inquiry meeting, [the manager] came to him and asked if he had mentioned the ‘blackmail’—and they were very specific used words—to the Commission of Inquiry. Max reported that [the manager] made statements that, ‘You know you’re old enough to go to Risdon, don’t you?’ Max appeared unsettled during the phone call and reported he was involved in several incidents that day. He expressed a wish to go to Risdon straightaway and that he wanted to give up on his exit plan.<sup>2415</sup>

On 14 November 2021, Commissioner McLean phoned Pamela Honan, Director, Strategic Youth Services, to disclose Max’s allegation. Commissioner McLean then wrote to Ms Honan the following day summarising Commissioner McLean’s discussions with Max.<sup>2416</sup> Commissioner McLean’s email to Ms Honan said that, on 9 November 2021, Max had told Commissioner McLean that the manager had told Max he could get Max the video games ‘if you don’t get involved in any political stuff/speaking with the [Commission of Inquiry or Commissioner McLean] because if you do then it gets taken out of our hands’.<sup>2417</sup> Commissioner McLean’s email also referred to her conversation with Max on 12 November 2021.<sup>2418</sup>

On 22 November 2021, when she returned from leave, Ms Honan forwarded Commissioner McLean’s email summary to the manager in its entirety, noting:

Events as reported by the C4C [Commissioner for Children and Young People].

Can you respond so that this is on the record and adopt the strategies we discussed moving forward re two staff present during conversations and documenting of conversations in shift notes.<sup>2419</sup>

On 25 November 2021, Ms Honan emailed Commissioner McLean, forwarding the manager's denial of Max's allegation and describing a meeting with the manager and Max.<sup>2420</sup> We describe this in more detail below. Ms Honan told Commissioner McLean that 'it was agreed by [Max] that he may have confused what [has] been told to him and taken it out of context'.<sup>2421</sup>

After this time, Commissioner McLean said that she continued to advocate for Max about his access to psychological support while at Ashley Youth Detention Centre.<sup>2422</sup>

## 4 The manager's recollection

In his evidence to us, the manager strongly denied Max's allegation. The manager said: 'I'm confident that I didn't bribe or incentivise Max to provide or not provide information to the Commission [of Inquiry]'.<sup>2423</sup> The manager also told us that 'at no time did I ever try to coerce Max into doing anything but provide his own evidence to the Commission [of Inquiry]'.<sup>2424</sup> The manager stated that he was 'actually pleased that [Ashley Youth Detention Centre] residents were speaking to the Commission [of Inquiry] because it's their voice that needs to be heard and in any child-centred approach that's what should happen'.<sup>2425</sup> The manager later noted that Max's conversation with Commissioner McLean about wishing to speak to the Prime Minister or Premier to tell them good things about the Centre occurred before Max's conversation with the manager that was the basis of Max's allegation.<sup>2426</sup> The manager observed that this timing tended to support his evidence that he did not attempt to bribe Max.<sup>2427</sup>

The manager recalled speaking to Max before Max's session with a Commissioner, which was held on 10 November 2021. At our public hearings, the manager agreed that before Max's session with a Commissioner he had discussed moving to a step-down unit, going off-property and access to MA15+ video games with Max and another detainee.<sup>2428</sup> The manager told us that access to MA15+ video games was something that Commissioner McLean had raised with him as well during this period.<sup>2429</sup> The manager said that he later told Commissioner McLean that he had considered the issue and thought it was reasonable for young people to be able to access age-appropriate video games.<sup>2430</sup>

The manager told us, however, that his discussion with Max was 'around [Max's] pathway forward and what he wanted to achieve' in the context of some deterioration in his behaviour.<sup>2431</sup> The manager said that he approached Max about his progress after an incident involving Max breaking into a prohibited area.<sup>2432</sup> He said that during the

conversation he and Max discussed Max's progress, his recent work experience and his plan to enrol in a TAFE course.<sup>2433</sup> The manager explained to us that at the time of the conversation, Max had wanted to enter a step-down unit before leaving Ashley Youth Detention Centre and to have access to MA15+ video games.<sup>2434</sup>

The manager recalled that before the discussion, Max had been involved in a range of incidents. The manager said:

In the time previously before that [Max] had destroyed a \$7,000 coffee machine, I think he'd broken two laptop computers, he'd broken into that building area, there had been quite a few incidents as part of his spiral sort of downwards, and we were trying to get him to come up from that.<sup>2435</sup>

We have had the benefit of reviewing the Department's registers of incidents at Ashley Youth Detention Centre, as well as the minutes of meetings of the Multi-Disciplinary and Centre Support Teams. The meeting minutes and incident registers provided to us do not appear to record the incidents as recalled by the manager, although they do indicate other incidents involving Max in October and November 2021.<sup>2436</sup> There was evidence of Max's involvement in a stand-off during the weeks leading to Max's session with a Commissioner. They do not record Max being involved in unauthorised entry to prohibited areas, or damaging property, between 1 October 2021 and 10 November 2021.<sup>2437</sup> The meetings of the Centre Support Team also describe Max's behaviour as 'polite', 'settled' and 'positive' before his session with a Commissioner on 10 November 2021.<sup>2438</sup>

The registers do, however, record incidents involving Max gaining 'unauthorised entry to a prohibited area' on 19 and 20 November 2021, after his session with a Commissioner.<sup>2439</sup> Similarly, the documents we have reviewed show that Max damaged a coffee machine and a computer in late November 2021, several weeks after his session with a Commissioner.<sup>2440</sup>

During our public hearings, the manager was asked whether his conversation with Max before Max's session with a Commissioner related to the information Max would provide at that session. The manager told us he could not recall such a conversation:

Q [Counsel Assisting]: So, [the manager], I'm sorry to interrupt you but you haven't answered the specific question which you were asked, which is, do you recall having a specific conversation with Max about the fact that he was going to give evidence to the Commission?

A [The manager]: No, I do not.

Q: And, are you saying that you never had such a conversation?

A: I can't recall a conversation about that.<sup>2441</sup>

The manager reiterated his denial that he attempted to bribe Max.<sup>2442</sup> The manager also told us that his conversation with Max ‘was absolutely nothing to do with him meeting the Commissioner’ and that ‘young people need to be heard, and the young people should be meeting with the Commissioner’.<sup>2443</sup> The manager also observed that Max is ‘very, very well spoken’ and ‘quite articulate’.<sup>2444</sup>

On 8 November 2021, two days before Max’s session with a Commissioner and in response to a query from Ms Honan about whether the manager needed any support to accommodate Max’s session with a Commissioner, the manager said:

I think that [the other detainee] and [Max] want to voice their opinion of [the Centre] and the support they receive, it could actually be a good opportunity for the centre.<sup>2445</sup>

In his later email to Ms Honan, the manager said Commissioner McLean had told him that Max and the other detainee had positive things to say about the Centre.<sup>2446</sup>

The manager told us he did not recall speaking to Max after the session with the Commissioner in relation to Max going off-property and moving to the step-down unit.<sup>2447</sup> He also said that after the session with a Commissioner, he spoke to Commissioner McLean and Ms Honan about Max’s allegation.<sup>2448</sup>

## 5 Ms Honan’s recollection

Ms Honan gave evidence in our hearings before Max and the manager gave their evidence. Therefore, during her appearance we did not ask her about the allegation made by Max. After her evidence, we asked Ms Honan to provide us with her account of events, which she did in a statement on 16 November 2022.

Ms Honan told us that Commissioner McLean raised Max’s allegation with her on 14 November 2021. Ms Honan told us she ‘viewed the concerns as serious’.<sup>2449</sup> Ms Honan said she spoke to the manager when she returned to work on 22 November 2021 and that this conversation covered ‘strategies’ including the manager having no individual contact with Max and documenting all conversations with him ‘to ensure clarity of conversations’.<sup>2450</sup> She said it was also agreed (although it is unclear by whom) that Ms Honan would meet with Max and the manager on 24 November 2021 ‘to discuss the concern’.<sup>2451</sup> As described earlier, Ms Honan also emailed the manager and asked him to respond to the allegation ‘so that this is on the record and [to] adopt the strategies we discussed moving forward re two staff present during conversations and documenting of conversations in shift notes’.<sup>2452</sup> This forwarded email contained all the details of Max’s complaint as captured and summarised by Commissioner McLean.

On 23 November 2021, the manager emailed Ms Honan in response to Ms Honan's email about Max's allegation. In that email the manager said that he had spoken to Max after being contacted by Commissioner McLean in relation to Max and another young person accessing MA15+ video games while they were detained at the Centre.<sup>2453</sup> The manager's email stated that Max was 'despondent' because 'the week before [his session with a Commissioner] he had led a stand off'.<sup>2454</sup> As noted above, the documents we reviewed record Max being involved in a stand-off in late October 2021.<sup>2455</sup> The manager wrote that he spoke to Max about him being able to go off-property, being able to access MA15+ video games and being moved to the unit being run as a 'semi-step down unit' once Max was 'on green' (a reference to Max being on the highest colour level for good behaviour on the behaviour management system—refer to Chapter 10).<sup>2456</sup>

In his email of 23 November 2021, the manager also told Ms Honan that Commissioner McLean had contacted him before the session with a Commissioner, who told him that Max and another detainee wanted to speak to our Commission of Inquiry about 'their lives at [the Centre] and how they felt it was their home and that they were treated well by the staff'.<sup>2457</sup> The manager told Ms Honan that he 'was surprised at first by this action but felt buoyed as it showed that we were doing our jobs well'.<sup>2458</sup>

In his email to Ms Honan, the manager denied Max's account of the conversation as described by Commissioner McLean, stating that he did not attempt to 'influence, bribe or blackmail' Max.<sup>2459</sup> The manager acknowledged that he 'did try to influence [Max] to improve his behaviour by suggesting that he may be able to go [f]ishing when Green and that MA15+ video games will be available in the semi step down unit', but that this was unrelated to Max's session with a Commissioner.<sup>2460</sup>

Ms Honan said that on 24 November 2021, following the manager's email, she met with Max and the manager together to discuss the allegation.<sup>2461</sup> Ms Honan told us that she spoke to Max separately before this meeting to discuss its purpose, to confirm Max was comfortable with the manager being present and to discuss the option of the meeting being ended if Max felt uncomfortable or became angry.<sup>2462</sup> No independent support person was present for Max at the meeting.

Ms Honan wrote to Commissioner McLean the following day, stating that she and the manager had met with Max and that Max had agreed that he 'may have confused what was ... told to him and taken out of context'.<sup>2463</sup> Ms Honan did not explain to Commissioner McLean why or how Max had been confused. Ms Honan later told us that, during the meeting, Max said he may have been confused by the conversation with the manager occurring 'so close to the time' of Max's session with a Commissioner.<sup>2464</sup>

Ms Honan also said in her email to Commissioner McLean that Max was now 'in a positive frame of mind' and was 'motivated to try and reach green'.<sup>2465</sup> Despite Ms Honan's instruction to the manager on 22 November 2021 that any conversations



with Max be documented, Ms Honan did not provide to us any notes recording the 24 November 2021 conversation in response to our request for details of her conversations and correspondence in relation to this matter.<sup>2466</sup> Ms Honan told us that she used her 25 November 2021 email to Commissioner McLean as her case note of the meeting with Max and the manager.<sup>2467</sup>

## 6 Findings

We do not make a finding, on the balance of probabilities, of whether or not the manager attempted to bribe Max. We found both Max and the manager's accounts plausible. We are concerned, however, by the response of Ashley Youth Detention Centre and the Department to that allegation.

### **Finding—Ashley Youth Detention Centre and the Department did not respond to Max's allegation appropriately**

Max's allegation against the manager was serious. We are concerned that the response to the allegation, including its investigation, did not reflect its seriousness.

Our concerns with the response to Max's complaint include the following:

- If Max's allegation were true, it would constitute, at least, serious misconduct. We received no evidence to suggest this possibility was considered or was raised with anyone in the Department other than the manager. The complaint might have been reported or referred to more senior management and human resources staff and advice sought about what steps to take, including whether the allegation should be referred to the Secretary to consider a disciplinary investigation.
- Ms Honan spoke with the manager before making any enquiries with Max and apparently provided the complaint from Commissioner McLean with all the details of Max's account to the manager. We consider it would be best practice to speak with the young person making the allegation before speaking to the person against whom the allegation is being made and then appropriately formulate and present the issues to which that person should respond.
- We received no evidence to suggest that Ashley Youth Detention Centre took steps to consider whether other detainees were relevant to the investigation of Max's allegation. While the Centre may not have been aware that Max alleged another detainee witnessed the bribe, it was known to the Centre that two detainees were seeking access to MA15+ video games and were participating in sessions with a Commissioner.

- We received no evidence to suggest that Ashley Youth Detention Centre took steps to gather information from any other Centre staff (including the Centre’s psychologist) who may have been aware of the allegation and may have had information relevant to Max’s complaint and what, if any, action they may have taken.
- Max was called into a meeting with two senior managers—one who he had accused of bribery (the manager) and that person’s superior (Ms Honan). We received no evidence to suggest that Max had an independent support person present in the meeting or any other accommodations to acknowledge the significant power imbalance in the room. We consider that the manager should not have been present at this meeting.
- There appear to be no records of the meeting between Ms Honan, the manager and Max beyond Ms Honan’s email the next day to Commissioner McLean. Given the seriousness of the allegations, a detailed record of the meeting and indeed the investigation process more generally should have been taken and recorded appropriately.

Overall, we consider there was not an appropriate response to what was a serious complaint from a detainee. We consider the response to Max’s allegation suggests systemic problems in how Ashley Youth Detention Centre and the Department respond to serious allegations, including by children and young people against staff members. We observed similar problems in the Department’s response to allegations of child sexual abuse against staff and in a complaint from Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, about the safety of children (refer to Case studies 5 and 7).<sup>2468</sup>

It is important that any investigation appropriately addresses the power imbalance between adults and children, particularly detainees who are highly dependent on staff while in detention. It is important, too, to manage the risk that the accounts of adults are preferred over those of children and young people, even where those children and young people may sometimes display challenging behaviours. Also, information gathering should include the accounts of others who may be able to provide clarifying or corroborating information. Finally, it is imperative that serious allegations be formally responded to in line with policy and procedures, and that this be properly documented. We are concerned that the way in which Ashley Youth Detention Centre responds to serious allegations may affect whether detainees raise allegations about child sexual abuse.

We discuss in Chapter 12 changes we consider can be made to strengthen independent individual advocacy for children and young people in detention through a new Commission for Children and Young People.

# Case study 7: Allegations of child sexual abuse against staff at Ashley Youth Detention Centre

## A note on language

In this case study, we use the term ‘Department’ to mean the department responsible for youth detention at the relevant time. From 2000 to 2018, this was the Department for Health and Human Services. From 2018, it became the Department for Communities (also referred to as Communities Tasmania). In October 2022, the department responsible for youth detention changed to the newly formed Department for Education, Children and Young People. Where there is potential ambiguity, we use the full name of the relevant department.

## 1 Overview

In this case study, we explore responses to allegations of the sexual abuse of detainees made against some Ashley Youth Detention Centre staff. There is a long history of allegations of abuse at the Centre, but this case study establishes that appropriately responding to allegations of child sexual abuse is an ongoing challenge for the Centre and the Department to manage. It is crucial that the Department has the policies and practices in place to identify and appropriately respond to allegations of staff misconduct related to children and young people at the Centre.

It can be difficult to get timely information about potential abuse perpetrated by staff in detention. As we learned in Case study 1, detainees may be fearful about speaking out against mistreatment, particularly if they are still in detention or likely to return. We heard that reporting or cooperating with authorities is heavily stigmatised among young (and adult) offenders, which can discourage reporting. However, we also observed that where young people did try to report concerns, they often recalled that these reports were not recognised as disclosures or allegations of abuse or were otherwise minimised or downplayed. We saw that many former detainees reported their mistreatment in adulthood, perhaps as they recognised and came to terms with what happened to them, felt safer to do so, or hoped that they would be believed this time.

There has been a steady escalation of allegations against current and former staff at Ashley Youth Detention Centre over several years. Establishing redress schemes (Tasmania’s Abuse in State Care Program and the later Abuse in State Care Support

Service, as well as the National Redress Scheme) became an important source of information for the Tasmanian Government to understand the nature and scale of potential abuses by current and former staff. The objective of these schemes is to recognise and acknowledge harm that occurs in institutional contexts and to provide some form of compensation for the impacts of abuse and mistreatment, but not to closely examine the conduct of alleged abusers. This can sometimes make it difficult for agencies to respond to information received, particularly where it relates to allegations from a long time ago or where there is limited detail about alleged abusers and their actions. More recently, there has been an increasing number of former detainees who have initiated civil action against the Tasmanian Government (most prominently, in a class action) alleging abuses while they were detainees.

This case study explores how the Tasmanian Government and other State entities have responded to allegations of child sexual abuse by some Ashley Youth Detention Centre staff, particularly in relation to information that it has received through redress schemes and civil action. In addition to the Department, we also discuss the role of the Department of Justice, Tasmania Police, the Registrar of the Registration to Work with Vulnerable People Scheme ('Registrar') and the Ombudsman in responding to allegations of abuse by Ashley Youth Detention Centre staff. This case study should be considered alongside Case study 1, where we found that for decades some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. However, we expect that some of the challenges (for example, in acting on information in National Redress Scheme applications) would be consistent among other institutions and government departments, in Tasmania and nationally.

## 1.1 The structure of this case study

We begin the case study by describing the key sources of information for allegations of abuse by current and former staff—including the Abuse in State Care Program, the Abuse in State Care Support Service, the National Redress Scheme and civil claims in Section 2. We then provide, in Section 3, some background for this case study, including an outline of the various responsibilities of agencies in responding to allegations against Ashley Youth Detention Centre staff. This includes the duty of care owed to detainees and reporting obligations to authorities such as Tasmania Police and the Registrar, and powers to address risks to detainees through disciplinary action.

The rest of the case study is set within a broad chronology, focusing on the response to allegations against staff over several key periods, noting these sometimes overlap. In Section 4, we describe how the Department responded to allegations against Ashley Youth Detention Centre staff arising from the Abuse in State Care Program between 2003 and 2013. We note that several claims were also received about out of home carers and about other state care contexts, although we have not examined these in detail. The section includes an explanation of legal advice the Department obtained

in 2007 from the then Solicitor-General on whether (and how) the Department could use information received through these claims. The legal advice at that time concluded no disciplinary action or police reporting could occur without the Department seeking a sworn statement from a complainant. While this legal advice (and the practice that emerged because of it) is a significant and recurring theme throughout this case study, we do not consider it was the sole reason for not using this information to protect children from further harm.

Section 5 covers the establishment of the Abuse in State Care Support Service in 2015 to replace the Abuse in State Care Program, noting that the Department continued to receive allegations against staff through this redress program.

We then describe, in Section 6, disciplinary processes undertaken against Ashley Youth Detention Centre staff from 2007 to 2018, which show examples of serious complaints sometimes being investigated by the Centre itself. This section reflects some of the challenges we have seen across the Tasmanian Government in applying the State Service disciplinary framework to allegations of inappropriate staff conduct towards children.

In relation to this period—2007 to 2018—we chose a case example to examine responses from agencies around this time. This case example is about a former staff member called Walter (a pseudonym), who was the subject of extensive and serious complaints of alleged abuse from a variety of sources.<sup>2469</sup> In that case example, we discuss an arrangement within the then Office of the Ombudsman that incorrectly resulted in some serious complaints made to the Ombudsman (including a complaint about Walter) being referred back to Ashley Youth Detention Centre for response without adequate scrutiny. This arrangement has since ceased but highlights the important role of robust oversight bodies in youth detention. We also saw significant problems in the response to complaints against Walter, which allowed for serious complaints to be managed through counselling, warnings and other minor sanctions for far too long. When a formal disciplinary investigation was initiated, it failed to consider the history of complaints against Walter in their totality and recognise an alarming pattern of behaviour within the allegations.

In Section 7, we note the introduction of the National Redress Scheme in 2018 and outline the processes Tasmania has adopted in responding to claims under this scheme.

We then look to 2019 and onwards in Section 8, which is when the Tasmanian Government began to receive information about current and former Ashley Youth Detention Centre staff through National Redress Scheme applications. We illustrate the key systemic issues we observed during this period with reference to the more recent case examples of Ira, Lester and Stan (all pseudonyms).<sup>2470</sup> Each of these staff members had serious and significant complaint histories relating to abuse of detainees that became apparent from 2019 and arising from claims to the Abuse in State Care

Program, the Abuse in State Care Support Service, the National Redress Scheme and civil litigation. We identify failings and shortcomings in the Department's responses to allegations against staff from 2019 to 2020, while noting some challenges it was facing.

In Section 9, we describe a welcome change in the Department's approach, with a greater focus on the public interest in the safety and wellbeing of children. We also note ongoing shortcomings in the Department's response to allegations against staff.

In Sections 10 to 12, we make observations about systemic problems from 2019 to 2021 regarding responses from Tasmania Police, the Registrar and the Department of Justice to alleged abuses by Ashley Youth Detention Centre staff.

We then, in Section 13, describe continuing departmental initiatives to improve records and responses to child sexual abuse from 2021, before making brief observations about more recent responses to abuse allegations against staff from the similar period in Section 14. In that section, we identify some areas of improvement—particularly in the timeliness of the response—that we want to acknowledge. However, we describe some of our ongoing concerns about the effectiveness of the Department's response to allegations. We also identify that staff morale re-emerges as a dominant consideration and warn against allowing this focus to come at the expense of the safety of children.

Overall, the problems we identify cannot be reduced to the decisions or actions of individuals—they occur in the context of a fundamentally broken system that struggles to prioritise the safety and wellbeing of young people in detention.

## 1.2 Approach to case examples

As mentioned, in this case study we include several case examples to help us understand the challenges and realities associated with responding to allegations of child sexual abuse. We have chosen these case examples to inform our understanding of the problems and to guide our recommendations. We examine case examples to varying degrees. For instance, we consider only some aspects of the response to allegations of child sexual abuse by Walter in detail to illustrate problems specific to that period (the mid-2010s). In more recent case examples, we were able to include greater detail about those problems and the extensive history of complaints about Walter.

With our case examples of Ira, Lester and Stan, which focus on the period from 2019 to 2020, we adopt a different approach. We examine these three matters in detail, like the approach we adopted for our health case studies in Chapter 14. We chose these examples because they were relatively recent, and we wanted to test the view that allegations of abuse in Ashley Youth Detention Centre were a problem in the past. Through our forensic review of these recent examples, we found that this was not the case. We observed a range of concerning practices that compromised detainee safety and exposed significant weaknesses in the Department's recent policies, practices and



systems to respond to allegations of abuse against staff. These case examples form the basis of our systemic findings in this and other case studies in this volume and have greatly influenced our recommendations in Chapter 12.

Because of how recent the case examples of Ira, Lester and Stan are, we have not been able to lay out our analysis of these matters in detail. This is because there are still legal and other processes underway associated with these matters and we do not want to compromise them. We also needed to respect certain legal obligations to protect the confidentiality of claimants under the National Redress Scheme and other redress processes, which form part of our review.

We had considered publishing but then suppressing our more extensive analysis of these three staff, but ultimately decided against doing so. We thought it in the public interest for the Tasmanian community to receive this information as soon as possible, to the extent possible. This meant we had to present the information differently and in a significantly truncated form. As a result, there may be times where it may appear our findings and recommendations lack some detail compared with other forensic case studies or even our case example of Walter. However, all the information on which we base findings and recommendations has been provided to the State, relevant agencies and witnesses, and has been the subject of considered procedural fairness processes. While we may not always be able to publicly reflect the extent of our knowledge, we consider our findings and recommendations to be well grounded. We spend some time in Section 2 explaining the sources of information we have relied on to show the rigour and breadth of our analysis.

We give a relatively high-level review of departmental responses to several cases involving allegations against Ashley Youth Detention Centre staff that came to light in 2021 and 2022. Because responses to these matters were in such early stages during our Inquiry, we did not request extensive information about them and have not individually described them. However, we wanted to see whether lessons had been learned from the responses to allegations against Ira, Lester and Stan and had translated into meaningful and promised change. While we saw some improvements, particularly in the responsiveness and the timeliness of notifications, we continue to have concerns, which are summarised thematically in Section 14.

It is important for us to state that, as far as we are aware at the time of writing, none of the staff who we examine in our case examples have been charged with any child sexual abuse offences. As we make clear throughout our report, it is not our role to investigate and substantiate specific allegations of child sexual abuse, which is ultimately a matter for police and other agencies. Our interest lies in how agencies responded to allegations and managed risks to children in circumstances where staff who were the subject of allegations had access to vulnerable children in an extremely high-risk setting for abuse—namely, a youth detention centre.



## 2 Sources of information

We faced enormous challenges gathering the information we needed to thoroughly assess allegations of child sexual abuse by staff at Ashley Youth Detention Centre, and the responses to them. We often felt we were completing a jigsaw within a jigsaw in our attempts to understand exactly what occurred, particularly in our case examples. Some of the challenges were:

- We received lengthy and complex witness statements only days before a witness was due to give evidence.
- Following our public hearings in December 2022, we received a tranche of documents relating to the allegations made against one staff member included as a case example, which limited our ability to test and compare the evidence we received. This included a critical 3 December 2019 Minute to the Secretary regarding Ira.<sup>2471</sup> We acknowledge that some witnesses were no longer with the Department or the State Service at the time they prepared responses to our requests or gave evidence at our hearings and, therefore, were not able to access and provide to us all relevant documentation. This was not, however, the case for all witnesses.
- We did not have access to all Abuse in State Care Program documentation, in part due to the extensive manual review of hard copy files that was required by the State in order to provide some of that information to our Commission.<sup>2472</sup> We discuss issues relating to record keeping regarding Ashley Youth Detention Centre in Section 8.5.2 throughout this case study.
- We could not have access to a multi-agency State Budget submission and related documentation because they were cabinet-in-confidence. We acknowledge that the Department provided us with some summary information about these matters.<sup>2473</sup>
- Evidence was sometimes vague, confusing or internally inconsistent. Very generalised evidence often sat alongside highly qualified evidence, which could be difficult to reconcile. At times, we simply did not receive answers to some questions we posed in our requests for statements from some witnesses, without explanation.
- We saw a lack of alignment between the information held between different agencies. For example, sometimes the Department would tell us a notification was made to Tasmania Police or the Registrar on a particular date—yet evidence from those agencies suggested the notification was made on a different date or not received at all. It was impossible at times to determine why such significant discrepancies existed and whether they arose due to simple human error, a failure in systems of sharing information and recording, or another reason (or indeed,

a combination of these factors). The nature of the information or documentation that was provided to agencies in these circumstances was sometimes difficult to determine—for example, was it in the form of a verbal overview, high-level written summary or all the relevant source material? This made it difficult to assess how reasonable responses were—particularly from the Registrar—in the context of the information they held.

Despite these challenges, we drew information from multiple sources to understand, to the best of our ability, how the Department, Ashley Youth Detention Centre and other key agencies responded to allegations of child sexual abuse by staff.

In the following sections, we summarise the key sources of information that we relied on.

## 2.1 Current and former detainees

We observed a general and understandable reluctance by some current and former detainees to engage with our Commission of Inquiry. We recognise the significant stigma attached to reporting, the justified and profound loss of trust in institutions many detainees may hold and the very real scepticism many can encounter when they seek to report offending due to assumptions about their character and reliability. We also acknowledge that some people may have had real and genuine fears about engaging with us (particularly current detainees) because of concerns they may have had about retribution due to their participation.

Notwithstanding these barriers, several current and former detainees (and their families) showed enormous courage in sharing their experiences with us—many of which we describe in Case study 1. Our review of documentation (for example, redress applications) has given us insight into other detainees' recollections of abuse and the impact their time in Ashley Youth Detention Centre has had on their lives. Where these people have chosen not to engage with us, we have been mindful of how we have presented information to preserve their anonymity, without sanitising the scale and impact of the abuses alleged.

Some witnesses warned us to be wary of detainees' claims, which reflected a tendency from some to attribute reporting of abuse as being motivated by financial gain or an effort to undermine staff.<sup>2474</sup> False allegations of child sexual abuse, while rare (estimated to be 2–5 per cent), do sometimes occur.<sup>2475</sup> We accept that there may have been instances where detainees threatened to make unfounded complaints and that such threats may have affected the way management considered allegations. As we reiterate throughout our report, it is not our role to determine whether individual abuses occurred.

While we do not dispute that false claims can be made, we did not see evidence to suggest a concerted and organised attempt to concoct or falsify allegations. Our close engagement with the evidence led us to conclude in Case study 1 that some children

and young people experienced systematic abuse and harm at Ashley Youth Detention Centre. We note that descriptions of the culture at the Centre reported by current and former detainees, either directly to us or through documentation, were striking in the patterns of behaviour they described. Aspects of these complaints, including the general attitudes of staff towards detainees and of the practices deployed by staff, were often corroborated or openly admitted by some witnesses including former staff, regulators or authors of past reviews into the Centre.

We are grateful for all the information we reviewed about detainee experiences and consider this information—whether provided to our Inquiry directly or indirectly—will improve awareness of abuses at the Centre and contribute to a safer future.

## 2.2 Current and former staff

We received statements from some current and former staff of Ashley Youth Detention Centre. This evidence greatly assisted us in confronting the very real challenges that staff at the Centre face every day. Many detainees are highly traumatised and can display a range of complex behaviours that are difficult to manage, which can threaten the safety of staff, other detainees or themselves. We learned that staff were sometimes fearful and felt unsafe in their work—an assertion we do not doubt.<sup>2476</sup> Some reflected feeling ill-equipped and unsupported in responding to the practical challenges that could arise in a dynamic and unpredictable environment, particularly due to understaffing or lack of adequate training.<sup>2477</sup> It was clear that the sharp scrutiny brought to bear on frontline workers at Ashley Youth Detention Centre, who are often working under immense pressure, was a source of considerable and legitimate distress for some staff.<sup>2478</sup>

Despite these challenges, we found some former detainees spoke positively about some staff who they felt had their best interests at heart and were not complicit in harmful and abusive behaviours.<sup>2479</sup> Some detainees observed these staff sometimes did not last long in the Centre or that they eventually became inculcated into poor practices.<sup>2480</sup> Our Inquiry also showed there were staff who advocated for and acted in the best interests of children detained at the Centre (refer to Case study 2). In considering and weighing evidence that was critical of staff, we took account of the need to consider their actions within the challenging context of their workplace.

One former staff member, Alysha (a pseudonym), began working at Ashley Youth Detention Centre in late 2019 and recalls that, shortly after, she was told by Ira (the subject of one of our case examples) that he had witnessed what he considered to be the aftermath of an incident of sexual abuse of a child by Lester.<sup>2481</sup> Alysha reported this in January 2020 and was distressed that her concerns were apparently not acted upon.<sup>2482</sup>

Alysha went on to raise concerns about how her report was managed (refer to Case study 5), and other issues, providing a detailed statement to us about her experiences working at Ashley Youth Detention Centre. Alysha's statement was invaluable to us in

drawing our attention to concerns about current staff and informing our lines of enquiry, noting we have verified many of her concerns by reference to documentation or the evidence of others. We know her decision to speak out about the conditions within the Centre, including through our public hearings, came at what she considered to be an enormous personal cost to her and her family. Without Alysha's evidence, we would not have been able to expose what we have about the treatment of children and young people in the Centre. We were struck by Alysha's steadfast determination and advocacy on behalf of all children and young people, particularly those in youth detention.

We acknowledge the hardworking and dedicated staff at Ashley Youth Detention Centre who performed to the best of their ability in a complex and challenging environment to meet the needs of children detained at the Centre and act in their best interests.

## 2.3 Key witnesses

We sought statements and information from key departmental staff. Their roles and responsibilities, as well as their tenure, are described in the introduction to this chapter and we recommend referring to this to provide necessary context to this case study.

We also sought oral or written evidence from representatives from other agencies, including:

- Peter Graham, former Registrar within the Department of Justice, who we understand held the role from August 2019 until October 2022.<sup>2483</sup> We have referred to Mr Graham as 'the Registrar' throughout this case study for clarity and brevity.
- Jonathan Higgins APM, former Assistant Commissioner of Operations, Tasmania Police, with responsibilities for the Northern, Southern and Western District commands and the Crime and Intelligence Command since 2019 and a career within Tasmania Police since 1999.<sup>2484</sup> We understand that Mr Higgins now holds the role of Deputy Commissioner, Tasmania Police. We refer to Mr Higgins as Assistant Commissioner through this case study to reflect the role he held while engaging with our Commission of Inquiry.
- Richard Connock, Tasmania's Ombudsman and Custodial Inspector, holding those roles since January 2014 and January 2017 respectively.<sup>2485</sup>

## 2.4 Documents relating to complaints about staff and disciplinary action

The Department has received allegations of child sexual abuse by staff from multiple sources over a long period. We have been given summaries of many of these complaints, as well as documents outlining disciplinary action taken in response, relating to the period from January 2000 to February 2023. In considering the responses to allegations made against Ashley Youth Detention Centre staff members, we have drawn information from a range of sources, including:

- spreadsheets provided by the Department of Justice and the former Department of Communities listing allegations made against Ashley Youth Detention Centre staff through the Abuse in State Care Program<sup>2486</sup>
- various documents related to the National Redress Scheme, including applications relating to alleged abusers at Ashley Youth Detention Centre and related ‘National Redress Scheme – Request for Information’ forms
- a spreadsheet compiled for senior departmental managers in or around October 2020 of Ashley Youth Detention Centre staff named in the Abuse in State Care Program, National Redress Scheme or civil claims<sup>2487</sup>
- departmental Minutes to the Secretary (including briefings about claims made through the Abuse in State Care Program, National Redress Scheme, civil claims and other complaints made by individuals), staff file notes, emails and meeting minutes (including the meetings of the Department’s Strengthening Safeguards Working Group that was convened in or around August or September 2020 to discuss the active employment matters at the Centre)
- documents provided by the Registrar about alleged abusers, including a table outlining the status of 69 people of interest relating to Ashley Youth Detention Centre (the table also included information the Registrar had received from Tasmania Police, Child Safety Services and the Department about some alleged abusers of interest to us)<sup>2488</sup>
- a table provided by Tasmania Police setting out the reports made to it about allegations against certain Ashley Youth Detention Centre staff members (the table also includes brief details on ‘[a]ny action or outcome’ resulting from allegations and the dates on which police reported matters to the Registrar and Child Safety Services through its reporting systems)<sup>2489</sup>
- several spreadsheets compiled by the Department that set out the disciplinary action it took in response to allegations of child sexual abuse raised against Ashley Youth Detention Centre staff.<sup>2490</sup>

Although we gleaned valuable information from each document, many contained significant deficiencies and much of the information was difficult to reconcile. This made us concerned about the accuracy of some of the information provided to us.

The Department for Education, Children and Young People acknowledged deficiencies in records when it provided us with the most recent ‘Employment Direction No. 5 tracker’ on 6 February 2023 relating to staff from the former Department of Communities (which has since been subsumed into the Department for Education, Children and Young People), telling us:

The information in the tracker has been compiled based on the records that were accessible at the time. We note that the Commission has requested information about historical conduct related matters, many that occurred prior to the creation of the Department of Communities Tasmania. We have reviewed the available records. For some matters the records available are incomplete. Therefore we have not been able to answer all questions ... Some of our responses are also based on ‘secondary’ records such as Minutes, but we have not been able to source the primary document.<sup>2491</sup>

We also reviewed several historical documents provided by Jacqueline Allen, former Acting Executive Director, People and Culture, in response to our requests for information. This includes documents concerning events that occurred before she started her role at the Department and in which she was not involved, and often where we had not been provided those documents in response to other requests. We were grateful for her efforts in this regard, as well as for her detailed statement.

## 3 Background

### 3.1 Responsibilities on the State to protect children and young people in youth detention

Before we describe the responses of the Department and other agencies to allegations of child sexual abuse by staff at Ashley Youth Detention Centre, it is important to understand the responsibilities these agencies have in protecting detainees from harm. Once a young person enters detention, they fall into the care of the State, which has a range of legal obligations to uphold their rights, wellbeing and safety.

We consider that, quite aside from these specific legal obligations, the State also has a moral obligation to do everything in its power to uphold the safety and best interests of children and young people in detention, to take active steps to support them to recover from past trauma and to address the core drivers of their offending. Providing this support for children and young people reduces their vulnerability to child sexual abuse in detention because they are less likely to reoffend and end up back in detention.

We also consider that a caring and supportive model of care increases the likelihood young people will disclose child sexual abuse when it occurs, because of an established trust in the adults around them.

### 3.1.1 Duty of care towards detainees and staff

The Department has a duty of care to children and young people in detention. Or, put another way, a duty to take reasonable steps to protect a detainee's health, safety and wellbeing. This duty stems from several sources, including the following:

- Under the *Youth Justice Act 1997* ('Youth Justice Act'), the Secretary (and, in practice, the Department) is designated as 'guardian' of all children and young people in detention.<sup>2492</sup> As guardian, the Secretary has the same rights, powers, duties, obligations and liabilities over children in detention as a natural parent of the child. Under the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') the Secretary is also responsible for decisions concerning the daily care and control of a child or young person in detention.<sup>2493</sup> The Youth Justice Act and the Children, Young Persons and Their Families Act also impose a wide range of additional duties on the Secretary related to children and young people in detention.<sup>2494</sup>
- The Secretary is also responsible for the security and management of detention centres and the safe custody and wellbeing of detainees.<sup>2495</sup>
- The State has a common law duty to exercise reasonable care for the safety of children and young people in detention.<sup>2496</sup>
- From 1 May 2020, the *Civil Liability Act 2002* ('Civil Liability Act') imposes a statutory duty of care on organisations to take reasonable precautions to prevent child abuse by people associated with the organisation, which can form part of a cause of action in negligence.<sup>2497</sup> This duty arises for abuse perpetrated after 1 May 2020 and does not apply retrospectively.
- From 1 May 2020, the Civil Liability Act also makes organisations vicariously liable for child abuse perpetrated by employees, including those whose relationship with an institution is akin to employment (such as a volunteer or sub-contractor).<sup>2498</sup> This duty arises in relation to abuse perpetrated after 1 May 2020 and does not impose a retrospective duty.

The Department also has obligations under the *Work Health and Safety Act 2012* to do what is reasonably practicable to provide a safe workplace for staff.<sup>2499</sup>



### 3.1.2 Reporting obligations relating to child safety

Across the period of this case study—the early 2000s to 2022—staff in a number of State Service bodies had reporting opportunities and obligations that related to the safety of detainees, some of which were mandatory. We note that even if, on the facts, there was not a mandatory reporting obligation imposed on staff in some of these bodies, best practice would be to make a voluntary report in circumstances where information suggests a potential risk to children.

The reporting obligations relating to the type of conduct we discuss in this case study include:

- Making a report to police about potential criminal conduct, acknowledging that the offence of failing to report the abuse of a child was only introduced on 2 October 2019.<sup>2500</sup> This obligation does not apply where the victim-survivor is over 18 and the person making the report believes on reasonable grounds that the victim-survivor does not want the information to be reported to police.<sup>2501</sup>
- Making a mandatory report to Child Safety Services under sections 13 and 14 of the Children, Young Persons and Their Families Act. Mandatory reporting obligations generally apply when there is a risk of child abuse and neglect. We have observed across the Tasmanian Government that there has been confusion about whether mandatory reporting obligations arise where information suggests a potential risk to children generally, rather than risk to a specifically identified child. We acknowledge that this uncertainty may have contributed to reports not being made. We have chosen not to explore this aspect of reporting in this case study but address reporting to Child Safety Services across other parts of this volume and our report more broadly.
- Making a report of ‘reportable behaviour’ to the Registrar since 27 November 2015.<sup>2502</sup> The Registrar is responsible for determining if a person should be registered to work with children and young people.<sup>2503</sup> To determine this, the Registrar undertakes a ‘risk assessment’ to determine if the person should be registered (if they are not already) and an ‘additional risk assessment’ to determine if a registered person needs to be removed from the register if it receives information during the course of a person’s registration.<sup>2504</sup> The risk assessments are based on a determination of acceptable or unacceptable risk to vulnerable people.<sup>2505</sup> Additional risk assessments are typically driven by reportable behaviour notified by reporting bodies.<sup>2506</sup> Where the Registrar determines to undertake an additional risk assessment, the Registrar has grounds for an immediate suspension while the additional risk assessment is undertaken.<sup>2507</sup> We discuss this reporting obligation and make an associated recommendation in Chapter 18.

We briefly discuss processes for sharing information with Tasmania Police and the Registrar as context for the case examples, including information from the National Redress Scheme.

## Reporting allegations from National Redress Scheme applications

Many of the allegations of child sexual abuse made against staff at Ashley Youth Detention Centre after 2019 came to the Department through the National Redress Scheme, which was established under the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth). Although there is a general prohibition on disclosing information gained through the Scheme except for the purposes of the Scheme, it is possible for agencies and their staff to share information they receive under the National Redress Scheme for child protection purposes, including enforcing criminal law or undertaking investigations or disciplinary processes related to child safety.<sup>2508</sup> This includes staff working in the Department of Communities (or now the Department for Education, Children and Young People), the Department of Justice and Tasmania Police. We consider this exception enables these agencies to share the information in National Redress Scheme applications with the Registrar and Tasmania Police, as well as between agencies for the purpose of undertaking disciplinary action. We have also relied on this provision to receive, review and use information from National Redress Scheme claims for the purposes of our Inquiry and report.

## Reports to the Registrar of the Registration to Work with Vulnerable People Scheme

The Registration to Work with Vulnerable People Scheme sits within the responsibilities of the Department of Justice.

Section 53A of the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') requires that reportable behaviours by a registered person are notified to the Registrar. 'Reportable behaviour' is defined as 'behaviour that poses a risk of harm to vulnerable persons, whether by reasons of neglect, abuse or other conduct'.<sup>2509</sup> The obligations apply to a 'reporting body', which includes the Department.<sup>2510</sup> Youth justice services have been a 'regulated activity' since 1 October 2015, requiring those working in such services to hold registration.<sup>2511</sup>

It is important to elaborate on the obligation to report to the Registrar because the interpretation of the obligation is important to the discussion in this case study.

A reporting body's obligation to notify the Registrar of reportable behaviour has existed since 27 November 2015.<sup>2512</sup> This includes an obligation to notify the Registrar of reportable behaviour that happened before 2015.<sup>2513</sup> However, before 1 February 2021, section 53A of the Registration to Work with Vulnerable People Act stated that the duty to report to the Registrar arose where a reporting body 'finds that a person has engaged in reportable behaviour'.<sup>2514</sup> The Registrar told us that his team always interpreted the term 'finds' liberally, imposing an 'expansive obligation' on reporting bodies to report risks of harm to vulnerable people.<sup>2515</sup> Notwithstanding this interpretation, we were told that the duty was applied by reporting bodies (including government departments) variably, with some interpreting the legislation as requiring a substantive finding of abuse, neglect or other relevant conduct before making a report.<sup>2516</sup>

The legislation has since been clarified to state that a reporting body must notify the Registrar if it ‘becomes aware by any means, or suspects on reasonable grounds, that a registered person has engaged, or may have engaged, in reportable behaviour’.<sup>2517</sup> As discussed later in this case study, the Department told us that, around September 2020 (before the changes to the legislation), it began immediately referring allegations to the Registrar following discussion between People and Culture and the Registrar about best practice and the Registrar’s broad interpretation of the term ‘finds’.<sup>2518</sup>

We note that there is nothing in the Registration to Work with Vulnerable People Act preventing a body from notifying reportable behaviour to the Registrar, even if they do not have a legal duty to do so. The Registrar told us that ‘the more reporting that we get, the better, and I would always encourage agencies, if in doubt, to provide [information]’.<sup>2519</sup> The Registration to Work with Vulnerable People Act contemplates the Registrar receiving information about reportable behaviour other than through the mandatory notification provisions, although there is less clarity about how this information is used.<sup>2520</sup>

In making such a report outside statutory requirements, the reporting body would need to ensure it does not breach any privacy provisions in the *Personal Information Protection Act 2004* (‘Personal Information Protection Act’). We consider, however, that sharing information for the purposes of determining risk assessment for registration purposes would satisfy relevant exemptions relating to individual or public safety that have been in place since the Registration to Work with Vulnerable People Act came into force.<sup>2521</sup> We acknowledge other statutory privacy provisions, such as those in the Youth Justice Act, may also need to be considered and complied with depending on the circumstances and the information being shared. We accept that the specific legal context and practicalities will need to be considered in each case.

As we outline throughout our report, having effective information sharing between agencies is a critical part of keeping children safe. Describing the importance of having a system of information sharing that works, the Registrar observed:

... the systems that we have to keep children safe rely on many actors performing their role, and that’s within an agency, it’s within police, it’s within my office; we all have a role to play. They are distinct roles, quite deliberately, and it’s important, and information sharing is really the core to that.<sup>2522</sup>

The Registrar told us that when a State Service agency becomes aware of child sexual abuse in a government or government-funded service, the Registrar should receive three notifications: a referral from Tasmania Police, a mandatory notification from Child Safety Services under the Children, Young Persons and Their Families Act (which should receive a report from the relevant agency), and a notification provided directly by the agency in accordance with its obligations under the Registration to Work with Vulnerable People Act.<sup>2523</sup> The Registrar receives nightly reports of notifications from Tasmania

Police and Child Safety Services that are matched against current registrants and applicants.<sup>2524</sup> The notification is typically followed by the notifier providing information one to five days later.<sup>2525</sup>

The Registrar told us that while there has been some improvement in the process of reporting in recent years, he still does not ‘routinely’ receive three notifications about each allegation.<sup>2526</sup> The Registrar also told us that other than one report in 2016, he did not receive any notifications of reportable behaviour relating to Ashley Youth Detention Centre until late 2020.<sup>2527</sup> We acknowledge that the lateness of this reporting may have stemmed from the narrow interpretation of the obligation to report under the earlier version of section 53A of the Registration to Work with Vulnerable Act, where a ‘finding’ was required. We note, however, there was, and still is, nothing preventing an agency from reporting reportable conduct making a notification of reportable behaviour, even if they do not have a legal duty to do so. We are concerned that the lateness of the Department’s change in practice for reporting shows a lack of prioritisation of the safety of children in detention.

By August 2022, however, the Registrar had received more than 300 notifications involving Ashley Youth Detention Centre staff (including those provided by the Department).<sup>2528</sup> From those notifications, the Registrar has identified 69 people ‘of interest’ with sufficient particulars and allegations of relevant conduct.<sup>2529</sup> Many of those allegations related to previous staff and spanned many years, including many that stemmed from rediscovering Abuse in State Care Program claims (discussed further in Section 9.2). Of those 69 people, 33 held registration at some point, including 28 who held registration when the notification was made.<sup>2530</sup> As a result, the Registrar initiated 28 additional risk assessments and requested further information from reporting bodies.<sup>2531</sup> As at 15 August 2022, 10 of those 33 were no longer registered, although only three of these were due to some form of active exclusion by the Registrar (suspension, cancellation or interim bar).<sup>2532</sup> Twenty-three remained registered, including:

- Five people who had been subject to a positive risk assessment, meaning that they could maintain their registration status.
- Two people who had been subject to a proposed negative notice stating that they posed an unacceptable risk to vulnerable people, and their registration status had been suspended. These were, at the time, proposed decisions because the registered person is afforded the opportunity to request that the Registrar reconsiders a negative risk assessment.<sup>2533</sup> We do not know the outcome of this process regarding these two people.
- Sixteen people who continued to be subject to an additional risk assessment.<sup>2534</sup>

In addition to the difficulties identified by the Registrar arising from the Department’s information-sharing processes, we understand that the primary source of allegations

of abuse relating to current and former staff at the Centre has been the National Redress Scheme, which made it difficult to take action to suspend or cancel registration. The Registrar told us:

The information provided to the National Redress Scheme is collected for a different purpose and is tested against a lower legal standard for a successful outcome. As such, the reports often contain limited particulars, lack clarity with regard to allegations and might not attribute conduct to any individual. For example, it is not uncommon for allegations provided in redress to be limited to a few sentences or a paragraph. Further, due to the lower legal standard, the allegations are often not tested in any way. This is appropriate for the purposes of the National Redress Scheme but can limit its usefulness in a risk assessment. The consequence of this is that there may be allegations which suggest conduct of the most serious kind but for which limited particulars exist.

Claimants to the National Redress Scheme have also typically declined to participate in or provide statements to Tasmania Police investigations relating to the alleged conduct. This, while understandable, further limits the ability for relevant information to be collected or for an appropriate criminal justice response. In the context of the alleged conduct of current and former staff, there are only two cases where Tasmania Police provided information which was in addition to any information provided by [Department of Communities] records.<sup>2535</sup>

Also, the Registrar described how National Redress Scheme claims ‘often don’t attribute specific conduct to individuals, but they may mention individuals in their statement as a whole’.<sup>2536</sup> We were also told that in many cases the Registrar did not receive the full National Redress Scheme application but instead received extracts or quotes, sometimes only one or two sentences in length and without the alleged abuser’s name.<sup>2537</sup> The Department of Justice considered that ‘in the majority of cases’, there was unlikely to be ‘sufficient information for the Registrar to “match” the alleged offender with a registration with any degree of confidence’.<sup>2538</sup> In our review of National Redress Scheme materials, we also observed such instances where the claimant did not include details, such as an alleged abuser’s name (an application does not require an alleged abuser to be specifically identified to be accepted and redress offered).<sup>2539</sup> We note, however, that this was not always the case—many applications we reviewed specifically named the alleged abuser or witnesses to abuse (albeit, sometimes with understandable spelling mistakes).

While we acknowledge that National Redress Scheme claims often contain limited particulars, we are also concerned that inadequacies in the Department of Justice’s processes meant that not all information received from the Scheme Operator (the Australian Government’s Department of Social Services) was shared with the former Department of Communities until 2020, and that this would have affected the information the former Department of Communities gave to the Registrar. We discuss the Department of Justice’s role in National Redress Scheme claims in Sections 7 and 12.

We were told that while the Registrar initiates an additional risk assessment for anyone who is named in a National Redress Scheme claim, it is ‘very rare’ that the claim will include substantial information about the nature of the conduct.<sup>2540</sup> However, we consider that the Registrar is required to consider the prospective risk to children when undertaking risk assessments rather than to substantiate information it receives. Based on our case examples, we make a finding in Section 11 that, on occasion, the Registrar appeared to adopt too high an evidentiary threshold in assessing whether staff with allegations against them posed an unacceptable risk to children. In Chapter 18, we make a recommendation to clarify what the Registrar should consider in making risk assessments.

### **Tasmania Police reporting to other agencies**

Tasmania Police is responsible for enforcing the criminal law. Police have several reporting obligations to other agencies concerning child sexual abuse, including to Child Safety Services and the Registrar.<sup>2541</sup>

We were told that Tasmania Police’s process for reporting to other agencies is an ‘automated process’.<sup>2542</sup> Tasmania Police uses the following systems:

- ‘Atlas’, which is an intelligence system that has an option for police to select ‘Presents a risk to vulnerable people’ via a check box.<sup>2543</sup> When this box is ticked, the system generates a notification that is sent to the Department of Justice as a notification to the Registrar.<sup>2544</sup> Police can also select ‘Child Safety Occurrences’ in Atlas, in which case the information is automatically shared with Child Safety Services.<sup>2545</sup> Our understanding is that the ‘Child Safety Occurrence’ would only be selected if the victim-survivor was still a child, reflecting that Child Safety Services’ focus is generally on the care and protection of a particular child at risk.<sup>2546</sup> This means that people whose behaviour may continue to place children at risk may not be recognised as such because the victim-survivor is now an adult.
- ‘Offence Reporting System’, which is a system for recording crimes and/or offences.<sup>2547</sup> Specific offences within the Offence Reporting System trigger a notification to the Registrar.<sup>2548</sup>
- ‘Online Charging’, which is a system used for recording those taken into custody or to generate court files.<sup>2549</sup> Specific offences trigger a notification to the Registrar.<sup>2550</sup>

Our understanding is that most police notifications to the Registrar in relation to allegations in National Redress Scheme applications would be sent through Atlas. While Assistant Commissioner Higgins described these reporting mechanisms as an ‘automated process’, he also agreed at our hearings that there is a manual and subjective element to the referrals made through Atlas.<sup>2551</sup> He explained that there are guidelines as to when a police officer should ‘tick the box’ that a person ‘presents a risk to vulnerable people’, but there is also a ‘human element’ that may result in human error and also introduces subjectivity into the process.<sup>2552</sup>



Some of the shortcomings of these notification processes became apparent to us through our case examples and were reflected in a lack of alignment in the dates reported by different agencies as to when they received certain information. We explore this further through our case study and discuss Tasmania Police responses to allegations against staff at Ashley Youth Detention Centre in Section 10.

### **National Redress Scheme ‘Child Safe Reports’ made to Tasmania Police**

Assistant Commissioner Higgins told us that Tasmania Police receives certain ‘Child Safe Reports’ as referrals directly from the National Redress Scheme through an Australian Government Department of Social Services secure email inbox.<sup>2553</sup> Reports can be either identifying (meaning the complainant provided consent for their personal details to be disclosed to police) or deidentified. All applicants are asked at the time of making an application if they consent to police contacting them.<sup>2554</sup> The Australian Government’s Department of Social Services (as the Scheme Operator) appears to have had this reporting procedure in place since August 2018 at the latest, the month after the National Redress Scheme began.<sup>2555</sup> We discuss this in Section 7.

The ‘Child Safe Reports’ are only referred to Tasmania Police where they meet a certain criterion, such as the abuse occurred in the past 10 years, children are at current risk of abuse, the alleged abuser is still working with children or where the alleged abuser may have children of their own.<sup>2556</sup> We understand the strict criteria for referrals were set by the Scheme Operator.<sup>2557</sup> We are concerned, however, that those criteria mean that relevant evidence relating to certain alleged abusers is not provided to Tasmania Police, particularly because we consider it would be difficult for the Scheme Operator to know (for example) whether a person works directly with children because this information is held by Tasmanian agencies such as the Registrar. It is for this reason we consider it important for the Department of Justice (and other departments) to apply active judgment to what should be reported to Tasmania Police rather than relying solely on an assumption that the Scheme Operator would have reported everything necessary. This active judgment may also be required to meet other reporting obligations. We discuss this in Section 12.

## **3.2 Disciplinary action**

Where a complaint is made about the conduct of a staff member, the Department may take action to assess whether there has been a breach of the staff member’s employment obligations, particularly those reflected in the *State Service Act 2000* and related State Service Code of Conduct. This can empower the Department to take a range of actions, including suspending an employee, investigating a potential breach and, in circumstances where a breach is substantiated, imposing sanctions (which may include termination).<sup>2558</sup>



We have summarised the key aspects of the disciplinary framework here to provide context for the case examples in this case study. For more detailed information on the disciplinary framework, refer to Chapter 20.

If an allegation of child sexual abuse is made against a member of staff, a preliminary assessment is conducted to collect and organise information to determine whether the matter should be referred to the Secretary, who would then decide if there should be an investigation for a breach of the State Service Code of Conduct. The Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector* ('Integrity Commission's guide'), which is discussed in Chapter 20, states that preliminary assessments should be used to quickly (within three working days) gather relevant information to determine whether there is a reasonable suspicion of misconduct and the most appropriate way to deal with the matter.<sup>2559</sup> The Integrity Commission's guide is clear that a preliminary assessment should not turn into an investigation and does not require the allegations to be defined.<sup>2560</sup> We were told, however, that the Integrity Commission's guide was contrary to the advice that had been previously provided by the State Service Management Office, although the nature of those differences was not explained to us.<sup>2561</sup> We discuss the role of the State Service Management Office in providing advice and guidance in Chapter 20.

The Secretary is empowered to take disciplinary action in line with Employment Directions, which most relevantly include:

- Employment Direction No. 4—Procedure for the suspension of State Service employees with or without pay ('Employment Direction No. 4—Suspension' or 'Employment Direction No. 4')
- Employment Direction No. 5—Procedure for the investigation and determination of whether an employee has breached the Code of Conduct ('Employment Direction No. 5—Breach of Code of Conduct' or 'Employment Direction No. 5')
- Employment Direction No. 6—Procedure for the investigation and determination of whether an employee is able to efficiently and effectively perform their duties ('Employment Direction No. 6—Inability'). This direction may apply when a person no longer has capacity to perform their role or does not have the minimum requirements for employment, such as holding registration to work with vulnerable people.

An allegation of child sexual abuse reflects potential misconduct and requires steps to be taken to address any risks of harm. The Integrity Commission's guide sets out potential immediate actions that an organisation can take when an allegation of misconduct is raised. This includes reporting allegations to police and external bodies, imposing a suspension, short-term changes to the duties or the physical location of involved parties, blocking or restricting access to data or information, and securing

appropriate evidence.<sup>2562</sup> The Integrity Commission's guide also notes support may need to be offered to affected parties and the safety of others be considered.<sup>2563</sup>

These Employment Directions can be used to remove or restrict an employee and, where serious breaches are substantiated, result in termination of employment.

With respect to suspensions, the Integrity Commission's guide states, among other things, that an employee can be suspended before or during an investigation and may be required when people are at risk or the alleged conduct is very serious.<sup>2564</sup> It also provides that consideration should be given to reassignment before suspension.<sup>2565</sup>

We understand reassignment in the context of a complaint raising child safety concerns may mean moving someone into a role in which they have no possibility of contact with children and young people. We saw some examples where such reassignment was not considered possible based on the nature of the role of some staff at Ashley Youth Detention Centre.

We also received evidence in the context of Ashley Youth Detention Centre that although an employee could not be suspended under Employment Direction No. 4—Suspension if an Employment Direction No. 5—Breach of Code of Conduct investigation had not begun, other action might be taken such as 'directing' the employee away from the workplace before beginning an investigation.<sup>2566</sup> We were told that any line manager could make such a direction.<sup>2567</sup> We understood this evidence to concern an employer's entitlement to issue a 'lawful and reasonable direction' to an employee, which can include, in some circumstances, a direction not to attend the workplace or perform any work while receiving full pay. Whether a direction not to attend work while receiving full pay will amount to a 'lawful and reasonable direction' or is in effect a de facto 'suspension' (such that it must comply with the terms of Employment Direction No. 4), will depend on all the circumstances of the particular case.

We prefer the view that the employer retains the capacity to immediately remove State Service employees from the workplace in circumstances of suspected misconduct (including by issuing lawful and reasonable directions that they not attend work) considering the State's duty of care to children and occupational health and safety obligations. However, the evidence presented to us suggests that this is a matter of some uncertainty and debate among those responsible for such decisions.

In Chapter 20, we describe some of the uncertainty within agencies around whether Employment Direction No. 4 enables immediate suspensions. We heard evidence that it would be useful if the scope of Employment Direction No. 4 was expanded so that suspension could occur on the grounds of child safety.<sup>2568</sup> We make a recommendation to achieve this in Chapter 20 (refer to Recommendation 20.6).

### 3.3 Department processes for responding to abuse allegations against staff

We observe in our case examples that up until late 2020, the Department did not have any documented or approved policies specific to conducting investigations and notifying other agencies of allegations of child sexual abuse by staff.<sup>2569</sup> This was surprising to us, given the nature of the Department's responsibilities for child safety and youth justice. Ms Allen told us that despite this, there were many informal policies and procedures that People and Culture followed.<sup>2570</sup> She referred, for example, to flowcharts relating to Employment Directions No. 4 and No. 5 that specifically outline the suspension and investigation process.<sup>2571</sup> The Department has since developed flowcharts to guide responses to allegations of child sexual abuse against staff, which we discuss in Sections 9.4 and 13.3.

Below, we outline what we understand to be the responsibilities for responding to allegations against staff based on the evidence we received from various departmental officials in our Inquiry.

On receiving a notification of an allegation of child sexual abuse by an Ashley Youth Detention Centre staff member, People and Culture makes an assessment on a case-by-case basis, which is ultimately determined by many factors. However, witnesses told us that the process since mid-2020 typically includes:

- conducting an initial assessment of the information to confirm whether the alleged abuser is a current Ashley Youth Detention Centre staff member and confirming relevant biographical information
- contacting the relevant manager/director to determine whether the employee is at work and their work schedule, having regard to the risk to detainees
- notifying authorities such as Tasmania Police and the Registrar, including a copy of the allegations and employment information, and staying in contact with those agencies 'to ensure a coordinated approach'
- informing the Deputy Secretary Corporate Services, Deputy Secretary Children, Youth and Families and the Director Strategic Youth Services 'to case conference and coordinate necessary immediate actions, so that Ashley Youth Detention Centre management can ensure the safety of residents'
- compiling and organising available and relevant departmental information and records including rosters, timesheets, closed-circuit television footage, detainee records, policies and procedures
- determining the availability of investigators and confirming that the proposed investigator has no conflicts of interest with the staff member being investigated

- preparing a Minute for the Head of Agency (in this case, the Secretary) to consider whether they have reason to believe a breach of the State Service Code of Conduct may have occurred (per Employment Direction No. 5) and whether it is in the public interest to suspend the employee (per Employment Direction No. 4), together with a draft letter to the employee, investigator appointment documentation and a briefing note to the Head of the State Service
- providing the employee with relevant paperwork, in conjunction with Ashley Youth Detention Centre management
- engaging with the appointed investigator, including providing any identified records
- providing the investigation report to the Head of Agency, Tasmania Police and/or the Registrar and liaising with the relevant staff member on their response to allegations
- undertaking activities to provide advice to the Head of Agency for their consideration and decision
- communicating decisions and outcomes to the employee, Tasmania Police and/or the Registrar.<sup>2572</sup>

We received conflicting evidence about the extent to which the Secretary would be briefed (including verbally) on details of allegations once senior departmental officials became aware of those allegations and before any formal documentation was prepared for initiating an Employment Direction No. 5 investigation.<sup>2573</sup>

It is the Secretary's role to make decisions about disciplinary action under Employment Directions, including investigating or suspending an employee, guided by the advice of the Department. We understand that there is no specific timeframe within which People and Culture must undertake a preliminary assessment, particularly given that the actions that may be required as part of that assessment are determined on a case-by-case basis.<sup>2574</sup> However, as discussed earlier, the Integrity Commission's guide states that preliminary assessments should be undertaken within three working days of receiving an allegation of child sexual abuse against a staff member.

Ms Allen told us that the factors taken into account when deciding whether to recommend a matter should be investigated include, but are not limited to, the risk of harm to children or young people; the severity of the matter; the potential severity of the outcome for the employee; whether the allegations are easily proven or disproven; the complexity of the matter; when the alleged conduct took place; whether the matter has already been dealt with or investigated; whether there is likely to be any evidence relating to the allegation; whether there is a pattern of similar complaints; the past conduct of the employee; and matters relating to public confidence.<sup>2575</sup>

## 4 2003–2013—Abuse in State Care Program claims

In this section, we outline the extent of allegations received through the Abuse in State Care Program from 2003 to 2013 and how the Department responded to these allegations, including any measures taken to protect children from the potential risks posed by staff. From at least 2007, the Department was on notice that current staff (of Ashley Youth Detention Centre, other parts of the Department and foster carers) were the subject of allegations of child sexual abuse when it sought legal advice on how it could use information arising from claims. As we discuss throughout this case study, based on this legal advice (and a practice that seemingly emerged because of it), the Department did not use information from Abuse in State Care Program claims to manage potential risks to children and young people from serving staff.

### 4.1 Allegations of abuse through the Abuse in State Care Program

People who were abused while under state care (whether in youth detention or out of home care) could make applications for compensation through Tasmania's Abuse in State Care Program between 2003 and 2013. Claims could relate to any kind of abuse (physical, emotional or sexual abuse, or neglect) by staff or carers. Claims could also be made by victim-survivors in relation to harmful sexual behaviour they experienced while in state care.

As we outlined in Case study 1, the Abuse in State Care Program received hundreds of claims related to abuse in Ashley Youth Detention Centre (or its predecessor, Ashley Home for Boys), including claims of sexual abuse.

The Department is the information custodian for Abuse in State Care Program records and had access to the claimant files.<sup>2576</sup> With the change in departmental structures, we assume the Department for Education, Children and Young People would now be the custodian. Despite this, as we explore in our case examples below, departmental knowledge of the existence of the Abuse in State Care Program was piecemeal and, as recently as 2020, senior members of the Department did not know that allegations had been raised through it against staff still working at Ashley Youth Detention Centre.

### 4.2 Departmental response to Abuse in State Care Program claims

We received limited evidence to suggest the Department took any action prior to 2020 in response to allegations made against current or former staff arising from Abuse in State Care Program claims, despite some describing serious sexual abuses.

A 4 November 2021 briefing to the Minister for Children and Youth said the Department had ‘not been able to source any records that indicates any action was taken against any employees as a result of the information provided through the State Based Redress Scheme’.<sup>2577</sup>

We did not receive evidence of the Department taking any steps in response to information from Abuse in State Care Program claims, such as reallocating the duties of staff, making notifications to other agencies or initiating disciplinary action.<sup>2578</sup> While the application form for the Abuse in State Care Program included a question to the claimant about whether they would like to make a complaint to the police, there was not a similar question about a claimant’s willingness to take part in any disciplinary processes if the person they alleged abuse against was still a State Service employee or a carer for children in the care system.<sup>2579</sup>

This inaction meant that Ashley Youth Detention Centre staff, who were the subject of allegations of child sexual abuse, continued working directly with children at the Centre over a long period.<sup>2580</sup> Quite apart from the potential for children to be harmed, it exposed the State to the financial risks of having to meet more compensation claims in the future.

We understand that part of the reason why the Department did not proactively act on information it received through claims was because of the purpose of the Abuse in State Care Program itself. The program was intended to be a healing and restorative act of recognition of past harm, rather than a way to test the veracity of claims or take further action. A December 2020 departmental review into the Abuse in State Care Program considered the notifications process associated with the Abuse in State Care Program as well as its scope and aims. The review noted:

... the aim of the [Abuse in State Care Program] process was not one established to ascertain blame or fault but rather to be part of a supportive, healing reconciliation process for those who suffered abuse in the care of the State. It was only when claimants specifically requested it, that matters were referred to police.<sup>2581</sup>

The 2020 review described steps the Department intended to take during the life of the Abuse in State Care Program to safeguard children if it was revealed that the alleged abuser continued to provide care to children in state care, which would include those working at Ashley Youth Detention Centre. The review quoted a discussion paper from 14 November 2003 (around the time of the first round of Abuse in State Care Program) that described the respective roles of the Ombudsman, the Department and the Independent Assessor, and said:

The Department was responsible for checking departmental records to find out if any named perpetrators were still in the State care system and if so, providing that the perpetrator had not already been referred to the Police by the Ombudsman, the claimant should be advised that the matter may be referred to Police for investigation ...<sup>2582</sup>



However, this review also quoted a 2004 Minute to the then Minister for Health and Human Services confirming the intention of the Abuse in State Care Program was never to test the veracity of claims or otherwise engage with alleged abusers:

Except in those cases where a matter has been referred to the Police at the request of a claimant, unless [the Independent Assessor] determines otherwise, no attempt is being made to put allegations to alleged perpetrators. Thus, while initially the Ombudsman and subsequently [the Independent Assessor] must be satisfied that the abuse occurred, it is not intended that there be specific findings made against alleged perpetrators, and ordinarily natural justice would require allegations to be put to alleged perpetrators so that they were in a position to deny, admit or otherwise comment on.<sup>2583</sup>

As the custodian of these records and due to its involvement in the operation of the program, the Department knew of serious allegations made about current and former staff at Ashley Youth Detention Centre.

In September 2014, former Secretary of the Department, Michael Pervan, (then in his first week as Acting Secretary) signed off on the *Review of Claims of Abuse of Children in State Care Final Report*.<sup>2584</sup> This report stated that during the period from 2011 to 2013, 172 claims were made against staff from Ashley Youth Detention Centre or Ashley Home for Boys, as well as hundreds of claims involving out of home care.<sup>2585</sup>

During our hearings in August 2022, Secretary Pervan acknowledged he was aware in 2014 that claims had been made alleging abuse at Ashley Youth Detention Centre at a high level and he did not ‘recall’ turning his mind to the question of whether alleged abusers named in the Abuse in State Care Program might still be working at the Centre.<sup>2586</sup> However, he did recall asking:

... regardless of whether they were employees or not, what happens with this information on the grounds that it was pretty clear that we were talking about horrible criminal offences, and I just asked the general question, ‘What happens with these?’, and I was referred to particular advice and a general practice which was current across government until late 2020 where matters raised in redress were not to be used for investigation, prosecution, and the assumption of course that would have been made by people in the People & Culture or Human Resources area was that, if we were told that they couldn’t be used for [Employment Direction No. 5 processes], then those matters weren’t open anymore, that they weren’t tracked across time. Of course, regardless now, in retrospect, regardless of that advice that we couldn’t pursue those matters, we should have come up with some way of keeping track of that information, I can see that.<sup>2587</sup>

The ‘particular advice’ Secretary Pervan is referring to is legal advice the Department sought in 2007 about whether (and how) it could use information received through Abuse in State Care Program claims (‘2007 Solicitor-General’s advice’).<sup>2588</sup> We discuss this in Section 4.2.1.



We understand that the limitations described by Secretary Pervan also applied to the out of home care context. We were not aware of all the detail about the Abuse in State Care Program, the Department becoming aware of it again, and the Solicitor-General's 2007 legal advice (or the practice that developed from it) when requesting information and conducting our public hearings into the safety of children in the out of home care system. Given we have not examined this issue closely, our findings are confined to failures to use this information regarding staff at Ashley Youth Detention Centre.

As will become apparent, the Department's awareness of the information arising from the Abuse in State Care Program seemed to diminish over time and be lost from much of the corporate memory until 2020.

#### **4.2.1 2007—Solicitor-General's advice on using information received through the Abuse in State Care Program**

Despite the intended purpose of the Abuse in State Care Program, the Department showed some concern about allegations against serving Centre staff in the early years of the program. As mentioned, in 2007 the Department requested legal advice from the then Solicitor-General on whether (and how) the Department could use information received through Abuse in State Care Program claims.<sup>2589</sup> Specifically, the 2007 Solicitor-General's advice was sought because the Department's review of the Abuse in State Care Program claims around 2007 had 'disclosed that a number of allegations of abuse were made against persons who are still either [out of home care] carers or are employed by the Department in some capacity'.<sup>2590</sup> Our Commission of Inquiry did not receive the request for advice which resulted in the 2007 Solicitor-General's advice. As such, we cannot assess whether the scope of the request affected the advice which was ultimately provided. On the face of the advice, the Department asked three questions of the Solicitor-General at that time:

1. Should prosecution be considered?
2. Should disciplinary action be considered?
3. Is some other action required to ensure proper protection for children in care either now or in future?<sup>2591</sup>

The then Solicitor-General advised, among other things, that to pursue any disciplinary action against current departmental employees on the basis of allegations made through the Abuse in State Care Program, the Department needed complainants to make statements under oath.<sup>2592</sup> The then Solicitor-General advised that the 'appropriate first step' was for the Department to contact complainants to see whether they would be willing to make a statutory declaration.<sup>2593</sup> The then Solicitor-General also suggested that the Department refer complaints that related to criminal conduct to police, if the complainant agreed and was willing to swear the allegations under oath.<sup>2594</sup>

The advice did not address the third question: ‘Is some other action required to ensure proper protection for children in care either now or in future?’ beyond a recommendation that the Department engage with complainants to determine their willingness to make statements under oath to facilitate disciplinary and other processes, as described above.

Importantly, the 2007 Solicitor-General’s advice extended beyond allegations against Ashley Youth Detention Centre to all departmental employees (including carers). Curiously, the advice did not address the need for any differences in approach between departmental employees and carers in the out of home care system (who are not employees and are not subject to the same procedural fairness requirements for disciplinary action).

#### **4.2.2 The effect of the 2007 Solicitor-General’s advice on the Department’s response to allegations of abuse**

We received varying evidence about the extent to which the 2007 Solicitor-General’s advice influenced the Department’s response to allegations from 2007 to December 2020.

Some senior leaders in the Department told us that the Department was required to follow the 2007 Solicitor-General’s advice and accordingly, the Department could not begin disciplinary action without the participation of the complainant.<sup>2595</sup> Secretary Pervan clarified that this was due to Department of Treasury and Finance rules.<sup>2596</sup> We were told that departmental leadership found this position ‘frustrating’.<sup>2597</sup>

During our public hearings, Secretary Pervan reflected on the prevailing view at the time, telling us that ‘it wasn’t just the practice’, adding that the inability to take disciplinary action on allegations raised through claims under the Abuse in State Care Program was a ‘very uncomfortable message that none of us were happy with’.<sup>2598</sup>

Secretary Pervan also responded to questioning by Counsel Assisting at hearings as follows:

Q [Counsel Assisting]: ... at around the time you were publishing the report in 2014 it appears that, because of practices that had come to exist, no one invited you to and you didn’t yourself reflect on the possibility of reaching out to some of those 172 claimants from Ashley Boys Home to see if any of them wanted to be part of a disciplinary process?

A [Secretary Pervan]: No, the assumption was that we could not.<sup>2599</sup>

While the 2007 Solicitor-General’s advice was specific to the Abuse in State Care Program, its principles appear to have extended into other types of claims. For example, it was cited as a barrier to responding to allegations of abuse arising from the Abuse in State Care Support Service (established in 2015), the National Redress Scheme, allegations reported by other staff and even civil claims.<sup>2600</sup>

We saw limited awareness of the 2007 Solicitor-General’s advice from some other witnesses. For example, Ginna Webster, Secretary, Department of Justice (who held Deputy Secretary and Secretary roles in the Department of Communities and its predecessor from July 2018 to September 2019) told us in January 2023 that she only ‘recently’ became aware of the 2007 Solicitor-General’s advice.<sup>2601</sup> Other departmental managers also told us they were unaware of the 2007 Solicitor-General’s advice until our Inquiry brought it to their attention.<sup>2602</sup>

The 2007 Solicitor-General’s advice was not referred to (including as a potential limitation in taking action against staff) in any of the Department’s extensive documentation about responses to allegations made in the redress schemes, civil claims or other complaints (and related documentation) that we reviewed.

Despite this, it appears that from at least 2007 a practice emerged within the Department that was based on, or related to, the 2007 Solicitor-General’s advice.<sup>2603</sup> That practice had the following features:

- Disciplinary processes were not pursued in response to allegations made through the Abuse in State Care Program based on an understanding that the Department could not do so without a sworn statement or the involvement of the complainant.<sup>2604</sup>
- The Department had no formal process for contacting complainants to get their statement or participation in a disciplinary process and did not do so as a matter of course (despite the Solicitor-General’s advice suggesting this was the appropriate first step in any attempt to act on allegations against staff).<sup>2605</sup> On this issue, Secretary Pervan conceded that there was nothing preventing those with responsibility for Ashley Youth Detention Centre at various points from contacting the complainants to check whether they would participate.<sup>2606</sup>
- The principle of not taking disciplinary action extended to complaints or allegations ‘where indirect evidence of abuse was raised’, including for allegations made through the Abuse in State Care Support Service, the National Redress Scheme, civil claims and complaints from employees.<sup>2607</sup>

This practice appeared to exist until late 2020. Secretary Pervan said the Department had its ‘hands tied’ until it received further legal advice on 15 December 2020, telling us:<sup>2608</sup>

... the advice from the Solicitor-General that effectively prevented us from using information provided in applications for financial compensation for disciplinary purposes, applied from 2007 until 15 December 2020. Our management of these matters changed with the change of position from the Solicitor-General.<sup>2609</sup>

We discuss this change in legal advice in Section 9.8.

We acknowledge that the 2007 Solicitor-General’s advice constrained some actions available to the Department around the time it was provided. We are concerned, however, that the practice that emerged from the advice appears to have been in place for more than a decade without apparently being revisited and reconsidered. We are particularly concerned that the establishment of the Registration to Work with Vulnerable People Scheme in 2014, and the associated reporting obligations in 2015, did not appear to trigger a reconsideration of how the Department handled and responded to allegations of abuse—noting that much of the information received through these claims would constitute ‘reportable behaviour’ under that Act. The National Royal Commission, which ran between 2013 and 2017 and highlighted failures to protect children within institutions, also did not prompt the Department to revisit this advice.

As we discuss in our case example relating to Lester, providing all the Department’s information holdings at the time the scheme was established would have revealed an extensive history of complaints made in Abuse in State Care Program claims that the Registrar could have considered in determining Lester’s suitability for registration. We consider the failure to take more active steps to use information from Abuse in State Care Program claims to have been a significant missed opportunity to protect detainees from potential risks to their safety.

### **Finding—From at least 2007 the Department should have taken more active steps to use information gained through state redress programs to protect children from the risk of harm**

From at least 2007 and possibly from 2003 when the Abuse in State Care Program began, the Department was on notice that some current staff at Ashley Youth Detention Centre were the subject of allegations of child sexual abuse and other abuses. From this point, it had an obligation to take active steps to protect children from harm.

It is not apparent what steps the Department took to investigate claims against staff before seeking advice from the Solicitor-General in 2007 on how it could act on the information it received. We are pleased it sought this advice.

It is regrettable that the 2007 Solicitor-General’s advice and associated departmental practices did not prioritise the safety and best interests of children. While we recognise the intention behind the Abuse in State Care Program was to be restorative for claimants (rather than a basis for action in relation to alleged abusers) we do not consider it in the public interest to have a situation where the

Department holds potentially credible information alleging serious abuses against current staff and carers (whether in the out of home care system or Ashley Youth Detention Centre) and does not act on that information.

We accept that the 2007 Solicitor-General's advice constrained some actions available to the Department around the time it was provided, including for taking disciplinary action against staff. However, we consider more could have been done to use the information received from 2007 to 2020 (when new legal advice was sought), including:

- contacting complainants to gauge their willingness to make a statement under oath and/or take part in other processes (including disciplinary and/or criminal justice processes)
- where there was no possibility of initiating formal procedures, taking all non-disciplinary measures available to protect children, including advising managers and supervisors of these claims against current staff to allow for greater vigilance and care in allocating staff duties and ensuring alleged abusers remained closely supervised
- ensuring relevant information was held on a staff members' personnel file to ensure any future complaints or concerns be considered in light of prior claims through the Abuse in State Care Program
- refining the design of the Abuse in State Care Program (noting there were four rounds) to maximise the ability of the Department to act on information it received; for example, this could occur by including a question directed at gauging an applicant's interest in supporting disciplinary action against their alleged abuser—and outlining the support an individual would receive should they choose to do so, to make such a process feel safe (claimants should also have been advised they could revisit this decision at any point)
- revisiting the 2007 Solicitor-General's advice sooner than December 2020, particularly given the significant changes to the legal and policy landscape as it related to child safety; for example, the establishment of the Registration to Work with Vulnerable People Scheme in 2014 should have triggered greater reflection on information that needed to be provided to the Registrar and the National Royal Commission should have invited consideration of the appropriateness of existing processes
- if fresh advice maintained the legal position of the 2007 Solicitor-General's advice, seeking ministerial approval for amendments to the legal constraints, recognising its practical effect was not sufficiently prioritising child safety and the public interest.

It appears that it was not until the Department sought further advice in December 2020 that it took any active steps to address the unsatisfactory outcome the 2007 Solicitor-General's advice (and associated practice) had created.

The Department's approach to Abuse in State Care Program claims prior to December 2020 enabled knowledge of the claims to become lost to a large portion of the Department's corporate memory. They were only rediscovered in 2020. This placed the safety of children in Ashley Youth Detention Centre at risk for years.

## 5 2015—Introduction of the Abuse in State Care Support Service

The Abuse in State Care Program was wound up in 2013 and replaced by the Abuse in State Care Support Service in 2015. The Abuse in State Care Support Service still operates today.<sup>2610</sup> Like its predecessor, the Abuse in State Care Support Service was established to support people who experienced abuse (including sexual abuse) in state care when they were children, including former Ashley Youth Detention Centre detainees.<sup>2611</sup>

As we discuss in Case study 1, departmental documents indicate that as at 20 July 2021, 26 claims had been made through the Abuse in State Care Support Service about allegations of sexual abuse at Ashley Youth Detention Centre (or its predecessor, the Ashley Home for Boys).<sup>2612</sup> Most of these allegations related to staff conduct at the Centre.<sup>2613</sup> The period of abuse from these claims spans 1995 to 2012.<sup>2614</sup>

We did not receive evidence that the Department took any steps prior to 2020 to identify if claims through the Abuse in State Care Support Service related to current staff.

## 6 2007–2018—Disciplinary action taken against Centre staff

In this section, we consider the way the Department approached (or as is the case in many instances, failed to initiate) disciplinary action against employees at Ashley Youth Detention Centre who were the subject of allegations of child sexual abuse between 2007 and 2018.

Again, during this period, we continued to see missed opportunities to use information gained from the Abuse in State Care Program and the Abuse in State Care Support Service to inform disciplinary action and ensure staff who posed a risk to detainees were not working at Ashley Youth Detention Centre.

As is the case across all areas of the State Service we have examined, we saw a conservative approach to initiating disciplinary proceedings, with disproportionate focus on procedural fairness at the expense of protecting the safety of children. This is discussed in Chapter 20.

We observed some key issues in the Department's approach to taking disciplinary action against employees accused of child sexual abuse, which includes:

- a lack of clarity and consistency in processes for managing complaints and allegations
- poor record keeping and failures to ensure all complaints and allegations about staff members were appropriately stored and accessible for future review
- failures to consider the cumulative effect of complaints and concerns about a staff member, including to identify patterns of behaviour
- using internal and more informal investigations to respond to serious allegations that should have been viewed as a potential breach of the State Service Code of Conduct and escalated to the Head of Agency.

The practical effect of these problems is that complaints made against Ashley Youth Detention Centre staff were not properly investigated, if at all, enabling them to continue to work with detainees. The failures of the disciplinary process are particularly apparent in the case example of Walter, which we describe in Section 6.2.

## 6.1 Summary of disciplinary and internal investigations between 2007 and 2018

In this section, we summarise information we received from the Department regarding disciplinary action it took between 2007 and 2018, with an overview of the nature of complaints received about staff and the response to those complaints. We have not limited this section to child sexual abuse and related conduct, including complaints about other forms of mistreatment of children and young people.

### 6.1.1 Disciplinary action between 2007 and 2018

From 2007 to 2018, the Department undertook several disciplinary investigations, including the following:

- In the late 2000s, the Department investigated an Ashley Youth Detention Centre employee over allegations of inappropriate physical force and inappropriate use of language.<sup>2615</sup> It appears from the information provided to us that two different detainees made allegations against the employee, resulting in a disciplinary investigation, with the outcome being ongoing training, supervision and a demotion.<sup>2616</sup>



- In the late 2000s, the Department suspended an Ashley Youth Detention Centre employee while a disciplinary investigation began over allegations including procuring and providing sexually explicit material to a child.<sup>2617</sup> The Department stood the employee down about seven days after it was notified of the allegations.<sup>2618</sup>
- In the early 2010s, the Department began a disciplinary investigation into two Ashley Youth Detention Centre employees over allegations that they brought pornographic material into the Centre.<sup>2619</sup> It is unclear whether these employees were suspended while the investigation was undertaken. The employees were sanctioned with reductions in salary and reassignment of duties.<sup>2620</sup>
- In the early 2010s, the Department initiated disciplinary investigations over allegations of physical and verbal abuse by one staff member and allegations of physical abuse by another. It appears that one of these employees was suspended four days after the Department received the complaint.<sup>2621</sup>
- In the mid-2010s, the Department began a disciplinary investigation into an employee involving allegations of physical assault that were also the subject of two police charges.<sup>2622</sup> The Magistrates Court dismissed these charges.<sup>2623</sup>
- In the mid-2010s, the Department began an Employment Direction No. 5—Breach of Code of Conduct investigation into Walter including because of allegations that he touched a detainee’s genital area.<sup>2624</sup> Walter had previously been the subject of five other investigations.<sup>2625</sup> The Department’s handling of the allegations regarding Walter is considered in Section 6.2.

### 6.1.2 Internal investigations between 2007 and 2014

From 2007 to 2014, Ashley Youth Detention Centre undertook several internal or informal investigations into the conduct of staff, including the following:

- A number of internal investigations were conducted in relation to Walter during this period. We discuss responses to allegations regarding Walter in Section 6.2.
- In the late 2000s, Centre management conducted a review into a staff member who had been the subject of a complaint to the Secretary about excessive use of force. The Secretary referred the complaint back to Centre management for review. The Department provided us with a spreadsheet that said the complaint was not substantiated and was referred to the Ombudsman ‘for further review if required’.<sup>2626</sup> In reflecting on the referral, the Ombudsman has told us that there is no mechanism under the *Ombudsman Act 1978* (‘Ombudsman Act’) for the Department to make such a referral.<sup>2627</sup> Another allegation against the employee was ‘referred’ to the Ombudsman in the early 2010s for alleged excessive use of force and that access to medical care was withheld.<sup>2628</sup> The Department told us that the Ombudsman did not make an adverse finding.<sup>2629</sup>

- In the late 2000s, the Department terminated a staff member’s employment over allegations including that he supplied a child at Ashley Youth Detention Centre with contraband in exchange for ‘sex[ual] favours’.<sup>2630</sup>
- Centre management conducted two reviews in the late 2000s into one staff member who had been the subject of a complaint to the Ombudsman in relation to alleged abuse and inappropriate comments, and another allegation about the use of excessive force.<sup>2631</sup> An Employment Direction No. 5 investigation ultimately began in the late 2010s over the allegations of excessive force.<sup>2632</sup>
- In the mid-2010s, Centre management conducted a review into a staff member who had been the subject of a complaint to the Ombudsman about alleged physical abuse.<sup>2633</sup> The Department told us that it did not have information about the final finding.<sup>2634</sup>
- In the mid-2010s, Centre management conducted a review into allegations that a staff member had made comments of a sexual nature and perpetrated sexual abuse during a search.<sup>2635</sup> The review included seeking clarification from the complainant, putting the allegations to the employee for comment and reviewing closed-circuit television footage.<sup>2636</sup> Management found that the allegations were not substantiated.<sup>2637</sup>
- On an unknown date, the Department conducted a review into allegations of verbal and physical abuse by a staff member.<sup>2638</sup> When more allegations of verbal abuse were later raised against the staff member, these were referred to the Area Manager with a recommendation for suspension (on an unknown date).<sup>2639</sup> The suspension was not actioned because the staff member was on workers compensation.<sup>2640</sup> The Department issued a direction that the staff member was not to interact inappropriately with children and contrary to the Child Protection Practice Framework.<sup>2641</sup>

## 6.2 Case example: Walter

In this case example, we consider responses to complaints made about a former Ashley Youth Detention Centre staff member, Walter (a pseudonym).<sup>2642</sup> Walter began working at Ashley Home for Boys and was an employee at Ashley Youth Detention Centre until the late 2010s.<sup>2643</sup> He held various roles at the Centre that involved working directly with children.<sup>2644</sup>

While we found many aspects of the Department’s response to Walter concerning, we have not examined all elements of it exhaustively. We have chosen three elements of this matter to illustrate problems and issues. This includes consideration of:

- the failure of the Department to recognise and act on, allegations received about Walter over several years that indicated a pattern of abusive behaviours, including allegations made through Abuse in State Care Program claims

- how the Office of the Ombudsman responded to a complaint from a detainee, Erin (a pseudonym), which led to her serious complaints being referred by the Office of the Ombudsman back to Ashley Youth Detention Centre for response without adequate independent oversight and scrutiny<sup>2645</sup>
- the Department’s approach to considering and initiating formal disciplinary action against Walter.

### 6.2.1 Complaints about Walter’s behaviour towards detainees

We examined a variety of sources about Walter’s conduct at Ashley Youth Detention Centre to understand his complaints history. This information was difficult to piece together due to the nature and complexity of the spreadsheets and documents we received from various State agencies and witnesses. In some instances, we have relied on information compiled by departmental witnesses who were not with the Department at the time of the alleged incidents and who were not involved in, or responsible for, the Department’s response.

What we did observe in the information available to us, however, was a significant pattern of serious allegations of abuse by Walter spanning two decades. Walter was the subject of at least 31 allegations of abuse, including child sexual abuse, made from the late 1990s to as recently as 2022—including through complaints made directly to the Department, the Ombudsman, the Commissioner for Children and Young People, through Abuse in State Care Program claims, civil claims, and reports to Tasmania Police.

The Department was aware of at least 19 of these allegations before Walter’s resignation in the late 2010s, with these 19 allegations raised with the Department from the late 1990s to the mid-2010s. The allegations of Walter’s abuse the Department received were extremely serious. They included inappropriate touching of female detainees, sexual abuse while strip searching a detainee, forced oral sex and rape. We also received evidence of allegations of physical abuse or excessive use of force.

We set out below, at a high level, some of the allegations made against Walter before his resignation, and the associated responses by the Department, Tasmania Police and other agencies.

**In the late 1990s**, two female detainees lodged complaints with Ashley Youth Detention Centre alleging that Walter touched them inappropriately.<sup>2646</sup> A third detainee also complained to the Centre, alleging that Walter failed to apply proportionate restraint.<sup>2647</sup> The Centre carried out an internal investigation into these three complaints during which Walter was suspended on full pay.<sup>2648</sup> As a result, Walter was required to undergo training related to at least one of these complaints and a ‘first and final warning’ was issued regarding the second complaint.<sup>2649</sup> In relation to the third complaint, Walter was issued with a notice, which we understood to confirm a finding that Walter had conducted himself ‘in an improper manner’ in the performance of his duties.<sup>2650</sup>

No further action was otherwise recommended.<sup>2651</sup> We understand Tasmania Police was notified about Walter's conduct at the time, but we are unclear of the specific allegations reported at this time.<sup>2652</sup>

**Between the late 2000s and early 2010s**, six people made Abuse in State Care Program claims in relation to Walter's conduct.<sup>2653</sup> The claims, which related to Walter's alleged conduct in the late 1990s and early 2000s, included allegations of sexual abuse while strip searching a detainee, forced oral sex and rape.<sup>2654</sup> We received no evidence to suggest any contact was made with the complainants who had lodged Abuse in State Care Program claims naming Walter to determine whether they would be willing to make a sworn statement—either to support a disciplinary investigation or investigation by police—which aligns with what we were told was necessary to act based on the practice at the time (refer to Section 4.2). We were also told the Department could not find evidence to suggest that the information from the Abuse in State Care Program was ever made available to those who supervised Walter or who were subsequently involved in the disciplinary investigations of him.<sup>2655</sup>

**In the early 2000s**, a male detainee disclosed that Walter had touched his genital area during strip searches.<sup>2656</sup> The matter was reported to the Centre and Walter was stood down for 48 hours in response to this complaint.<sup>2657</sup>

**In the late 2000s**, a female detainee alleged that Walter sexually abused her and that a staff member witnessed the incident but did not intervene.<sup>2658</sup> Tasmania Police found there was no evidence to support the allegations and closed the matter.<sup>2659</sup>

**In the late 2000s**, a complaint was made to the Ombudsman about Walter's restraint of a detainee, which allegedly caused their genitals to be exposed.<sup>2660</sup> We did not consider this matter in detail.

**In the early 2010s**, Walter was alleged to have physically abused a female detainee and entered her room after viewing her through the door viewing panel.<sup>2661</sup> The Department became aware of this complaint via a referral from the Ombudsman.<sup>2662</sup> Mr Connock, who was not the Ombudsman at the time, told us that the Office of the Ombudsman carried out preliminary inquiries into the matter and found that the use of force involving Walter was unjustified and 'showed a weakness in his conflict resolution skills'.<sup>2663</sup> Mr Connock also told us that Centre management advised that Walter had been formally counselled and received remedial training.<sup>2664</sup>

**In the early 2010s**, a former detainee, 'Erin', made a complaint about Walter's alleged sexualised behaviour towards her.<sup>2665</sup> We describe the Ombudsman and Department's response to Erin's complaint in Section 6.2.2.

**In the mid-2010s**, a detainee complained that Walter was physically threatening and intimidating towards him.<sup>2666</sup> We understand this complaint was raised through an internal complaints process. Walter was given a 'lawful and reasonable direction' in response.<sup>2667</sup>

**In the mid-2010s**, it was alleged that Walter touched a detainee’s genital area, as well as having engaged in inappropriate use of force and failing to report the incident in line with Ashley Youth Detention Centre procedures.<sup>2668</sup> The Commissioner for Children and Young People, Child Safety Services and Tasmania Police were made aware of this complaint.<sup>2669</sup> We understand the Department notified Tasmania Police about this allegation.<sup>2670</sup>

In addition to the allegations the Department was aware of, **in the mid-2010s**, the then Commissioner for Children and Young People made a notification to Child Safety Services about an allegation that Walter had tried to touch a detainee’s genitals.<sup>2671</sup> The notification stated that the future risk was low because the young person was no longer in custody, Walter was being investigated and the Centre had taken necessary steps to ensure other children were not at risk.<sup>2672</sup> This complaint was not included in the Department’s information to us about Walter’s complaints history.<sup>2673</sup>

Below, we explore two specific responses to allegations raised against Walter. We note generally, however, that the information we received about allegations against Walter from the Department, the Registrar and Tasmania Police was confusing and inconsistent. Based on the information the Department provided, we could not always tell which allegations were reported to Tasmania Police or the Registrar, and the dates and allegations in each of their respective responses to us did not align.

We note with some concern that the Registrar told us that the first notification he received was about the mid-2010s allegation that Walter had touched a detainee on his genital area, which was reported approximately four weeks after the allegation was made.<sup>2674</sup> Based on our chronology, the Department was aware of at least 12, and potentially as many as 21, previous complaints about Walter at this time. We acknowledge the obligation to report only arose in 2015 and that there was some confusion around reporting obligations to the Registrar until the Department’s practice changed in 2020. However, we consider Walter’s extensive complaints history to be vital information for the Registrar. This is particularly the case because decisions about granting registration to work with vulnerable people can protect children in a broader range of settings (for example, volunteer and other activities).

We note that Walter’s registration to work with vulnerable people was only cancelled in the early 2020s after the Registrar received new information about the serious history of complaints against Walter around that time.<sup>2675</sup>

### **6.2.2 Erin complains about Walter to the Ombudsman in the mid-2010s**

Erin told us about her experience as a detainee at Ashley Youth Detention Centre, where she was sexually and physically abused by staff (particularly during strip searches) as well as abused by other young people in detention, which we outline in Case study 1.<sup>2676</sup>

Erin told us that about a month after arriving at the Centre in the mid-2010s, she was feeling unwell and was worried she had appendicitis.<sup>2677</sup> She recalled she told Walter and asked to see the nurse.<sup>2678</sup> She said Walter told her to lift her top up, felt around her lower abdomen and drew a shape near her hip, telling Erin it was a ‘happy appendix’.<sup>2679</sup> Feeling violated and that his actions were ‘creepy’, Erin told us she reported the incident to a female staff member, who advised Erin to report it to the Ombudsman.<sup>2680</sup> Erin also described an incident where Walter entered her room to collect sheets while she was showering, despite Erin’s request that Walter send a female staff member to collect the sheets, or waited until she finished showering.<sup>2681</sup>

The Ombudsman told us the office received a complaint that ‘the staff member had touched the resident’s stomach and drawn a line with his finger near her hipbone’.<sup>2682</sup> By the time Erin made a complaint, the Ombudsman had already received at least two other complaints against Walter, which are described earlier.<sup>2683</sup>

Two weeks after Erin submitted her complaint, she received a letter from the Office of the Ombudsman that stated that the Ombudsman had an ‘arrangement’ with the Department in which ‘complaints such as yours are initially referred back to Ashley management to attempt to resolve the complaint quickly and efficiently’.<sup>2684</sup> The letter went on to state:

The sort of complaints that are referred are ones that appear to relate to matters such as the application of Ashley’s Behaviour Development program or where it seems likely that Ashley management can resolve the matter through discussion with staff and the young person.

I expect that a senior staff member will speak to you about your complaint in the near future. I am confident that your complaint will be resolved through this process and I will not contact you about it again. I will be notified of the outcome of any discussions with you by the Manager at Ashley.<sup>2685</sup>

In response to the referral from the Ombudsman, Centre management initiated an internal investigation into Erin’s complaint, which included a review of closed-circuit television footage and obtaining a statement from Walter and witnesses.<sup>2686</sup> In relation to the allegation that Walter drew on Erin’s body, Walter described this as an attempt to calm Erin’s nerves and emphasised that other staff and detainees were present.<sup>2687</sup> Regarding the allegation he entered Erin’s room while she was showering, Walter said another staff member was present just outside the room and that he [Walter] could not see Erin from where he stood in the room.<sup>2688</sup>

Ultimately, Centre management accepted Walter’s version of events.<sup>2689</sup> Centre management concluded that Walter did not have any inappropriate intent, but he should have realised that his conduct was likely to make Erin feel uncomfortable and potentially feel unsafe.<sup>2690</sup> Referring to the similarities between Erin’s complaint and the other detainee complaint to the Ombudsman made around this time, Centre management reflected that there was ‘insufficient sensitivity on [Walter’s] part to gender



considerations'.<sup>2691</sup> It said Walter's actions in both instances were 'ill-advised' and made him 'susceptible to a complaint such as this'.<sup>2692</sup> Walter was not sanctioned but was formally counselled and asked to conduct himself with greater sensitivity and focus on gender awareness.<sup>2693</sup>

We have not sought evidence of the processes adopted as part of this investigation and accordingly, do not make conclusions regarding whether the Department took appropriate action in this investigation. However, we note that it is our understanding Erin was not interviewed as part of this internal investigation, which appears to have been conducted outside the State Service disciplinary framework.

Erin had been released from the Centre by the time the Office of the Ombudsman received the Department's decision about her complaint.<sup>2694</sup> Mr Connock, who was not the Ombudsman at the time but worked in the Office of the Ombudsman, told us 'no action was taken by the Ombudsman's office other than to note the outcome', which he considered a 'questionable decision'.<sup>2695</sup> Erin told us that she was never notified of any outcome, and she had to continue seeing Walter in her two subsequent admissions to Ashley Youth Detention Centre.<sup>2696</sup> Speaking of the consequences she faced when she returned to the Centre after her complaint, Erin said staff called her a 'dog' and a 'drama queen'.<sup>2697</sup> She felt it was 'pointless' speaking up and she learned that it was easier to not say anything at all.<sup>2698</sup>

We were surprised by the letter from the Ombudsman's office to Erin, which made mention of an 'arrangement' by which complaints were referred back to the Centre, particularly given the Ombudsman's involvement in administering two rounds of the Abuse in State Care Program. This involvement should have made the Office of the Ombudsman aware of the number of complaints of abuse and mistreatment made against Ashley Youth Detention Centre staff and raised questions about the appropriateness of referring complaints back to the Centre.

We acknowledge that under the Ombudsman Act, the Ombudsman's powers are to investigate a public authority's administrative action, not individual officer conduct.<sup>2699</sup> In practical terms, this means the Ombudsman is responsible for reviewing the Department's (and Centre's) systems, practices and decisions made, rather than any specific misconduct by Ashley Youth Detention Centre staff. When complaints were made about particular staff members, we were told that the Ombudsman would investigate the manner in which the Department had responded to the complaint and what legal framework, policies and procedures were in place to mitigate against the circumstances of the complaint arising again.<sup>2700</sup> However, Mr Connock also acknowledged that the Ombudsman should have more closely considered and monitored the Centre's responses to Erin's complaint and other serious allegations.<sup>2701</sup> In Chapter 12, we discuss the Ombudsman's role and associated powers when responding to complaints about the treatment of children and young people at Ashley Youth Detention Centre.



Mr Connock told us he considered the referral of Erin’s complaint back to the Centre to be a ‘mistake’ by a less experienced staff member and said that the type of allegations that were intended to go back to Centre management under the arrangement were ‘low level things’ such as ‘not enough jam’.<sup>2702</sup> Mr Connock said that the arrangement should never have been used to refer any complaint that included an element of sexual abuse or harassment.<sup>2703</sup> He considered that a more experienced staff member would not have reached the same conclusion as the one reached in Erin’s case.<sup>2704</sup> In any event, Mr Connock confirmed that the ‘practice has long been discontinued’.<sup>2705</sup>

We accept Mr Connock’s view that Erin’s complaint was referred back in error and that this practice would not occur today. We are concerned, however, by other evidence we received about this ‘arrangement’. In addition to Erin’s complaint, we have reviewed four letters dated between 2009 and 2013 from the Office of the Ombudsman in response to complaints made against various Ashley Youth Detention Centre staff members. Those letters, prepared by two different staff members of the Ombudsman’s office, used similar language to the letter relating to Erin referring to this ‘arrangement’ where complaints were referred back to Ashley Youth Detention Centre management. These complaints did not include allegations of child sexual abuse or related conduct but related to issues such as ‘the application of AYDC’s Behaviour Development program’ and ‘staff attitude and behaviour towards residents’.<sup>2706</sup> They also included a complaint by a child at the Centre who had been locked in his room and a complaint that a staff member told other detainees that he would give them contraband if they ‘bash[ed]’ the complainant.<sup>2707</sup>

We do not consider complaints of this kind to be minor because they relate directly to the human rights and safety of detainees. On this basis, we do not consider the referral of Erin’s complaint back to the Centre was a one-off human error. We are also concerned about the integrity of the processes that were in place in the Office of the Ombudsman at that time to ensure inappropriate referrals were not made.

We are pleased Mr Connock shared our concerns about Erin’s complaint and that the arrangement where ‘minor’ complaints are referred back to Ashley Youth Detention Centre has since ceased. We make recommendations about oversight of Ashley Youth Detention Centre in Chapters 12 and 18.

### **6.2.3 Employment Direction No. 5—Breach of Code of Conduct investigation into Walter’s conduct in the mid-2010s**

Walter was investigated (internally or by the Ombudsman) on at least five occasions before the Department started an Employment Direction No. 5 investigation in the mid-2010s.<sup>2708</sup>

As mentioned earlier, in the mid-2010s Ashley Youth Detention Centre management became aware that a detainee had made a complaint against Walter, alleging that Walter

had touched him in the genital area. A preliminary investigation into the matter indicated that Walter may have touched the detainee but did not necessarily make contact with his genital area.<sup>2709</sup> There were concerns that the contact may have constituted an inappropriate use of force.<sup>2710</sup> A meeting was held with Walter in which the allegations were put to him and he was invited to provide a written response to the claims.<sup>2711</sup> Walter was also informed that due to the nature of the allegations, he would be assigned alternative duties with no contact with detainees while the matter was investigated.<sup>2712</sup> This direction appears to be a result of ‘preliminary investigations’.<sup>2713</sup>

In a written response, Walter acknowledged that he touched the detainee but rejected the allegation that he touched the detainee in the genital area.<sup>2714</sup> He explained that no force was involved and provided a justification for touching the detainee.<sup>2715</sup>

Soon after, the detainee reported his complaint to the Commissioner for Children and Young People.<sup>2716</sup> The matter was also referred to the police at the detainee’s request and was reported to Child Safety Services.<sup>2717</sup>

We understand that Walter went on leave immediately after Centre management put the allegation to him and did not return to the Centre before his resignation.<sup>2718</sup>

Later, but before Walter’s resignation, the then Acting Deputy Secretary – Children, approved a Minute recommending an Employment Direction No. 5 investigation into Walter.<sup>2719</sup> The three grounds on which the Employment Direction No. 5 investigation was based (and ultimately proceeded) were in relation to allegations that Walter had touched the detainee in the genital area, failed to use non-violent crisis intervention techniques, and failed to report the alleged incident relating to inappropriate contact in line with the Department’s Standard Operating Procedure.<sup>2720</sup>

The Minute also included a heading ‘Related Prior Incidents’, which referred to previous concerns and allegations that had been raised against Walter. These were included to show that on several occasions Walter may have potentially shown a lack of care and diligence in his interactions with some detainees.<sup>2721</sup>

The Minute provided details of ‘the most recent incidents’ involving Walter. This included the two complaints made to the Ombudsman in the early 2010s as well as another allegation made by a female detainee in the late 2000s, which the police found to be ‘unsubstantiated’.<sup>2722</sup> The advice to the Acting Deputy Secretary stated: ‘While past incidents cannot be used in making a determination or severity, they can be used to establish a pattern of behaviour of which to determine risk’.<sup>2723</sup>

Consistent with the practice of not using information received through Abuse in State Care Program claims, the Minute did not mention any of the six claims made under that scheme. Surprisingly, the Minute also did not mention a late-2000s complaint to the Ombudsman or the seven other complaints that were known to the Department about

Walter at this time. As a result, 14 separate allegations about Walter, some of which were very serious allegations of child sexual abuse, were omitted from the Minute.

An independent investigator appointed to investigate the allegations provided their final investigation report. The report concluded that there was no case to answer over the substance of the allegations under investigation because the investigator did not believe inappropriate contact had occurred.<sup>2724</sup> Consistent with instructions from the Department, the investigator did not have regard to any previous allegations (noting they did not receive the complete complaints history in any event).<sup>2725</sup>

The Acting Deputy Secretary approved a Minute about the Employment Direction No. 5 investigation report after receiving that report.<sup>2726</sup> The Minute recommended that there be no further action on the matter.<sup>2727</sup> It did not refer to any previous allegations or propose any disciplinary action.

While the first Minute to the Acting Deputy Secretary included the advice that past incidents could be used to establish a pattern of behaviour on which to determine risk, Walter's conduct was ultimately assessed based on the investigation of a single incident, without reference to a potential pattern of behaviour. We were told that other than brief periods where Walter was stood down from work, there does not appear to have been any other action taken in respect of repeated complaints about his behaviour.<sup>2728</sup>

Following this disciplinary process, Walter made a number of WorkCover claims.<sup>2729</sup> Walter ultimately left the Department in the late 2010s by mutual agreement and received a lump sum payout.<sup>2730</sup>

Secretary Pervan agreed that an opportunity was lost to protect children entering Ashley Youth Detention Centre from the potential harm posed by Walter over this period.<sup>2731</sup> Reflecting on the opportunities lost during the period in which the Abuse in State Care Program information was coming in, he said:

I agree that there was a lost opportunity to identify [Walter] as an individual against whom multiple allegations had been made. However there was no guidance on the use of this kind of information in employment decisions provided by the [State Service Act] or [Employment Directions] insofar as matters had already been tested and resolved (it is my understanding that double jeopardy applies in disciplinary proceedings). If the full history had been presented to me we would have sought urgent advice from the Solicitor-General on how to proceed given our intent to take action. I assume the advice of the Solicitor-General on our options would be different today ... than they were prior to the revision of the 2007 advice.<sup>2732</sup>

We agree this was a lost opportunity.

## **Finding—The State Service disciplinary framework, including its application and interpretation by the Department, did not facilitate an appropriate response to allegations and complaints about Walter (a pseudonym) from the late 1990s to the mid-2010s**

We identified several areas of concern with the disciplinary response to Walter. These reflect systemic problems across the State Service, including the following:

- To protect the procedural fairness rights and privacy of Walter, previous complaints (including Abuse in State Care Program claims) alleging sexual abuse by him were not considered (and therefore, not considered cumulatively) in investigations, despite these suggesting increased risks to child safety.
- The accounts of adults appeared to be favoured over the accounts of children and young people.
- Fragmented and poor record keeping made it difficult to gain a complete picture of Walter’s past conduct and complaints history.
- Complaints that were made directly and exclusively to Ashley Youth Detention Centre management or the Department were managed ‘in-house’ and relatively informally (if at all).
- While some of the internal reviews had greater formality, such as the early 2010s referral from the Ombudsman’s office about Erin’s complaint, they did not appear to have been conducted in line with formal disciplinary processes (despite potentially constituting a breach of the State Service Code of Conduct).

We were particularly concerned that reviews and investigations into Walter’s conduct were episodic and fragmented. This significantly undermined consideration of the seriousness of Walter’s cumulative conduct, which meant there was no meaningful consideration given to assessing and managing risks he may have posed to detainees.

We have seen multiple examples where past complaints or concerns about a person’s conduct have not been acted on due to real or perceived limitations in the industrial framework relating to previous unsubstantiated allegations. We consider the case of Walter to be an extreme manifestation of this problem.

We consider that previous allegations and complaints, not just those that are formally substantiated, could and should be considered in disciplinary processes against a staff member. They should be given appropriate weight and consideration that recognises the extent to which they were investigated and the basis for them

not being substantiated. A previously unsubstantiated matter does not mean it did not occur but that it could not be proven on the balance of probabilities. We note the significant evolution and understanding of the dynamics of sexual misconduct and abuse of children has contributed to a much more sophisticated appreciation of complaints of this nature now compared with the past. Even the criminal justice system, which requires proof beyond reasonable doubt of the alleged offence, now allows consideration of evidence that suggests a tendency towards a 'sexual interest' in children.<sup>2733</sup>

The lack of record-keeping systems to ensure all information was taken together (including information from Abuse in State Care Program claims) also contributed to these shortcomings.

Secretary Pervan conceded that there was a system failure in how the Department responded to information it held about Walter.<sup>2734</sup>

#### 6.2.4 Observations

Because responses to this matter occurred a number of years ago, we have been able to include more detail about some elements of the Department's response compared with much more recent examples relating to Ira, Lester and Stan in Section 8 (which concern alleged offending of similar seriousness).

While we are pleased some of the problems we saw in this case example have since been addressed, we did see a striking number of similar themes continue to arise in more recent responses. This includes failures to:

- recognise certain allegations as constituting child sexual abuse and treating them with the seriousness and urgency they deserved
- consider and give adequate weight to the cumulative effect of multiple complaints over time, which suggest a significant pattern of alarming behaviour
- act on information received in Abuse in State Care Program claims due to actual or perceived barriers
- apply the State Service disciplinary framework for conduct that may constitute a breach of the State Service Code of Conduct in favour of internal investigations that did not have the level of rigour and independence that would be expected
- make appropriate notifications to other agencies, including Tasmania Police and the Registrar, in a consistent and timely manner
- keep clear and consistent records internally, but also across agencies, relating to information received about an alleged abuser and complaints about them.

We revisit some of these themes in Section 8.5 based on our examination of responses to allegations about Ira, Lester and Stan.

## 7 2018—Introduction of the National Redress Scheme

The National Redress Scheme began in 2018. It is available to people who experienced sexual abuse in institutional settings before 1 July 2018.<sup>2735</sup> While the purpose and design of the National Redress Scheme is focused on recognising and alleviating the impact of child sexual abuse, information provided through it is valuable to assessing and understanding current risks to children. The Department started receiving National Redress Scheme claims regarding Ashley Youth Detention Centre employees from 2019.

The National Redress Scheme is administered by the Australian Government through its Department of Social Services, which is the Scheme Operator ('Scheme Operator'). Tasmania's Department of Justice (through the Child Abuse Royal Commission Response Unit) coordinates the Tasmanian Government's participation in the National Redress Scheme.<sup>2736</sup> Ginna Webster, Secretary, Department of Justice, told us:

Where the National Redress Scheme identifies the Tasmanian Government as potentially responsible for the abuse alleged in an application, the Scheme Operator notifies the Tasmanian Government. The notification provides the Tasmanian Government with a copy of the relevant parts of the application. This includes details of the claims as it relates to the Tasmanian Government institution but not details of any other claims made by the applicant.

The relevant Tasmanian Government institution is then required to retrieve any relevant records and prepare a summary of the retrieved records and provide those documents to the Scheme Operator.<sup>2737</sup>

The Department of Justice described the 'relevant parts of the application' it receives from the Scheme Operator as 'redacted and curated' parts of the full National Redress Scheme application as lodged by the claimant.<sup>2738</sup> We understand that this is not unique to Tasmania as the Scheme Operator does not provide a copy of the full National Redress Scheme application to any institution.<sup>2739</sup>

### 7.1 Department of Justice process for responding to the Scheme Operator

We were told that Tasmania is the only jurisdiction that has centralised the processing of National Redress Scheme applications.<sup>2740</sup> We understand that the purpose of this centralisation is to 'ensure that the State of Tasmania provides [the Scheme Operator] with a consistent and timely response to its requests'.<sup>2741</sup>

The Department of Justice will often liaise with other Tasmanian Government agencies to gather information that is relevant to assessing claims.<sup>2742</sup>

We were told that the process the Department of Justice adopted before October 2020 involved the following steps:

- The Department of Justice's Child Abuse Royal Commission Response Unit summarised the claim based on the redacted and curated aspects of the claimant's application it received from the Scheme Operator and identified the relevant agency (or agencies) the claims related to (such as the Department).<sup>2743</sup>
- The Department of Justice included its summary of the claim in a 'National Redress Scheme – Request for Information' form. The 'National Redress Scheme – Request for Information' form included questions as to whether the agency holds records that document the abuse, whether there are any records of a prior payment to the complainant (for example, ex gratia payments) and whether there are records that show the alleged abuser is still an employee of the Tasmanian Government and/or working in a child-related activity.<sup>2744</sup> That form was sent to relevant agencies to complete based on any records searches or other material they may have held. We understand the Department of Justice sent this form to agencies within 24 hours of the claim details being provided by the Scheme Operator.<sup>2745</sup> If the agency needed more information, it would need to ask the Department of Justice for the complete information it received from the Scheme Operator.<sup>2746</sup>
- The relevant agency then reviewed its records to answer queries and supplement any information and returned the 'National Redress Scheme – Request for Information' form to the Department of Justice.<sup>2747</sup> The agency was expected to include information on relevant claims received through the Abuse in State Care Program or Abuse in State Care Support Service in its response.<sup>2748</sup>

From around October 2020, the Department of Justice changed its practice and began to pass on all information it held to agencies, rather than summarising the already redacted and curated material from the Scheme Operator. This is discussed in Section 9.4.

If allegations in National Redress Scheme claims relate to Ashley Youth Detention Centre, it is the Department's role to determine whether the alleged abuser is a current staff member or otherwise represents a continuing risk for children and to address that risk through its own processes.<sup>2749</sup> This includes making relevant notifications to agencies such as the Registrar.<sup>2750</sup>

The Tasmanian Government does not have contact details for claimants and is not permitted to contact them directly. If the Department needs more information about a claim or claimant (including to contact them) it notifies the Department of Justice, which then approaches the Scheme Operator to organise this.<sup>2751</sup>



## 8 2019–2020—Department management of increasing abuse allegations against staff

By the end of 2018, the Department had been notified of various allegations of child sexual abuse occurring at Ashley Youth Detention Centre, including through the Abuse in State Care Program and the Abuse in State Care Support Service, through other agencies (such as the Ombudsman or Commissioner for Children and Young People) and directly from detainees.

From 2019, however, the Department saw an increasing number of allegations made against Ashley Youth Detention Centre employees. This was partly due to the start of the National Redress Scheme in 2018, with allegations first being made against Ashley Youth Detention Centre staff through this scheme from 2019. Gathering information in response to National Redress Scheme claims also contributed to the rediscovery of several Abuse in State Care Program claims relating to serving staff.

The Department received at least eight National Redress Scheme claims relating to Ashley Youth Detention Centre staff members or contractors (or those of its predecessor, the Ashley Home for Boys) in 2019.<sup>2752</sup> Some of these claims contained multiple allegations against several staff members, and the conduct was alleged to have occurred between 1994 and 2008.<sup>2753</sup> Some of those claims were made by former detainees who had also already reported their abuse in other ways, including through state redress processes.

We received evidence that the Department was not equipped to deal with the allegations that were coming in during this period, with Kathy Baker, former Deputy Secretary, Corporate Services attributing this to the Department being in:

... unfamiliar territory regarding how to handle these matters which were historical in nature, with poor record keeping practices, new personnel within the Department and the distributed nature on which the matters came into the Department.<sup>2754</sup>

The challenge of responding to National Redress Scheme claims would not be limited to Tasmania, as institutions across Australia also began to receive allegations of abuse against current and former staff and volunteers.

From 2019, the Department began to grapple with how to respond to this information. It was only from October 2020, however, that we saw the Department take active steps to improve its processes and responsiveness to information received through National Redress Scheme claims. This arose in the context of a steady escalation in the number of allegations from this period, as well as increased media reporting on institutional responses to child sexual abuse in late 2020. We outline the Department's responses to these increasing allegations in the following sections, with reference to the specific case examples of Ira, Lester and Stan.

## 8.1 Context for our review of responses to Ira, Lester and Stan

We have examined more recent responses to allegations against three Ashley Youth Detention Centre staff members—Ira, Lester and Stan (all pseudonyms). This included making multiple requests to the State, Tasmania Police, the Registrar and departmental witnesses for details of the allegations against Ira, Lester and Stan, and the responses to those allegations.<sup>2755</sup>

For a range of legal and procedural reasons, we cannot outline our analysis to its full extent in this report. However, these case examples have significantly informed our recommendations. Even based on the information that we have published, we consider these relatively recent examples of responses to allegations of abuse by staff at Ashley Youth Detention Centre are significant cause for concern. Particularly, as noted in Section 6.2.4, many of the problems we identified in the case example of Walter continued to feature in these more recent examples.

By around 2020, it became clear that the Department was facing an unprecedented crisis, with several staff being the subject of allegations. There were multiple competing demands relevant to the protection of children in such circumstances, including protecting children from people who may pose a risk to child safety, ensuring enough staff presence to allow children and young people to undertake their normal routines safely, as well as avoiding reinforcement of negative attitudes about detainees.

In considering responses from the Department to allegations against Ira, Lester and Stan, we kept several factors front of mind. We took seriously what we understand to be the very real challenges of running a youth detention centre, particularly during this period. Evidence from current and former staff, our site visits, private meetings and submissions all helped inform our understanding of these challenges. This includes:

- The impact of the onset of the COVID-19 pandemic, particularly in 2020, would have been a significant and consuming issue for the Department. Much of the work of the Department involved delivering essential frontline services that needed to continue, in some form, through the pandemic. This includes consideration of how to manage a child protection system that required active monitoring of at-risk children and young people and how to ensure risks of COVID-19 infections could be mitigated and managed in closed facilities such as Ashley Youth Detention Centre. The Department also assumed responsibility for Tasmania’s hotel quarantine program. Several staff were seconded and diverted during this time.
- There has been a longstanding struggle to maintain adequate staffing at Ashley Youth Detention Centre. Youth justice is a difficult environment, and this can make recruitment and retention of suitably skilled and qualified staff challenging. We recognise that understaffing creates significant operational challenges and that the

scale of allegations against staff (and media attention around aspects of this) would have had a significant impact on other staff at the Centre.

- It is often difficult to take disciplinary action against conduct that is alleged to have occurred many years ago, as is often the case for claims made under the Abuse in State Care Program and the National Redress Scheme. There may be little prospect of establishing corroborative evidence due to the passage of time or complainants not wishing to participate in disciplinary processes.

The Department was notified of serious allegations of abuse about Ira, Lester and Stan. While we do not itemise these specifically and do not always link them to particular staff members, this information included allegations of rape, forced oral sex, exposure of their genitals to detainees and watching detainees in the shower or while they masturbated. Claims sometimes also included allegations of physical violence or threats that occurred in connection to the alleged sexual abuse. Many allegations referred to multiple instances of abuse, as opposed to one-off occasions. One allegation was made about child sexual abuse occurring in the community by one of these staff members.

We provide summaries of responses to these allegations below.

## 8.2 Case example: Ira

Ira is one of many Centre staff who began working at what was then known as Ashley Home for Boys and held multiple operational roles, including as a youth worker, until his suspension in November 2020.<sup>2756</sup>

### 8.2.1 Allegations against Ira and the Department's response

In 2019, the Department received information outlining allegations from two former detainees of Ashley Youth Detention Centre that involved Ira. This included allegations Ira witnessed or was involved in abusive strip searches, inappropriately watched detainees in the shower and that he coerced detainees to perform sexual acts upon each other for his own sexual gratification.

- In April 2019, the Department was notified of allegations from a former detainee, Parker (a pseudonym).<sup>2757</sup> Parker alleged that he was subjected to abuse at Ashley Youth Detention Centre.<sup>2758</sup> Parker did not link Ira to any specific incident of abuse or mistreatment but listed him among other staff as being somehow involved. As we describe throughout this case example, at some time point, Parker's allegations about Ira essentially fell by the wayside and were only 'rediscovered' by the Department almost a year later in October 2020.
- In September 2019, the Department was notified of allegations against Ira by another former detainee, Baxter (a pseudonym).<sup>2759</sup> Baxter alleged that Ira sexually abused him on multiple occasions and engaged in other forms of mistreatment (along with other allegations not involving Ira).<sup>2760</sup>

Almost a decade earlier, Parker and Baxter lodged Abuse in State Care Program claims alleging abuse by Ashley Youth Detention Centre staff and had each received ex gratia payments as a result.<sup>2761</sup> Those Abuse in State Care Program claims made similar allegations about the kind of abuse each endured at Ashley Youth Detention Centre, but neither named Ira. Both claims described the incidents as causing psychological damage and otherwise having a negative impact on their lives.<sup>2762</sup>

In September 2019, Ira was placed on restricted duties for reasons unrelated to abuse claims or disciplinary matters. Senior members of the Department told us that this meant Ira did not work directly with detainees from September 2019, although he remained on site at Ashley Youth Detention Centre.<sup>2763</sup> We received assurances that these restricted duties suitably mitigated the risk relating to the allegations against Ira. However, Stuart Watson (who was Assistant Manager from January 2020 and Acting Centre Manager from March 2020) told us he did not become aware of the allegations against Ira until March 2020 and only did so incidentally.<sup>2764</sup> In that context, we find it difficult to understand how Centre management could appropriately monitor Ira's engagement with detainees if it did not know the secondary purpose for which his restricted duties were being relied on. We received some evidence that suggested Ira was able to undertake activities with detainees (including on a one-on-one basis) even while he was on restricted duties.<sup>2765</sup> Ultimately, we do not know if Ira did in fact engage with detainees while on restricted duties, but we are concerned there was no clear restriction or safeguards to prevent him from doing so.

On 7 October 2019, an 'ad hoc' meeting between a range of senior departmental staff was convened to consider allegations raised against current employees, including through the National Redress Scheme, and to determine any required actions.<sup>2766</sup> The meeting also considered the information received in 2019 relating to Parker and Baxter naming Ira, but it is unclear whether their earlier Abuse in State Care Program claims were acknowledged or discussed in this meeting.<sup>2767</sup> The minutes of the meeting recorded a number of action items, including a review of Ira's files and otherwise trying to gather more information with a view to providing advice to Mandy Clarke, then Deputy Secretary, Children, Youth and Families.<sup>2768</sup> It was agreed that the next meeting would be held 'when the information associated with the actions of the meeting is available'.<sup>2769</sup> We did not receive information about this further meeting, including whether it occurred.

Two months later, on 3 December 2019, information about the allegations against Ira were included in a Minute to Secretary Pervan, which was described as a 'preliminary review' of the information arising from both claims.<sup>2770</sup> We note that the Minute focused almost exclusively on Baxter's allegations (which specifically named Ira as an alleged abuser) and recommended that Baxter's allegations be referred to Tasmania Police.<sup>2771</sup> The Minute also advised that the Department was empowered to act on the allegations it had received for disciplinary and risk management purposes, including by referring matters to Tasmania Police and the Registrar.<sup>2772</sup> The Minute did not refer to or otherwise

acknowledge limitations imposed by the 2007 Solicitor-General's advice for acting on the information and, in fact, identified options for the Department that were inconsistent with the 2007 Solicitor-General's advice and the practice that emerged from it. The Minute recommended that Secretary Pervan defer a decision on whether to conduct an Employment Direction No. 5—Breach of Code of Conduct investigation until advice was received from Tasmania Police.<sup>2773</sup>

Due to human error, the Department did not refer Baxter's allegations to Tasmania Police until February 2020.<sup>2774</sup> Tasmania Police advised, in February or March 2020, that it would not be investigating Baxter's complaints.<sup>2775</sup>

We received no evidence to suggest that the Department took any steps to pursue disciplinary action against Ira until August 2020 at the earliest, despite there being no impediment in doing so from the perspective of Tasmania Police.<sup>2776</sup>

In September 2020 (a year after Baxter's allegations were received), Ms Clarke approved a Minute to Secretary Pervan recommending that the Department put Baxter's allegations to Ira (outside of the Employment Direction No. 5 process) to gather more information given that Ira was 'at the stage of transitioning back to resident contact' because his restricted duties were ending.<sup>2777</sup> It was envisaged that the information gathered from this process would be used to consider whether an Employment Direction No. 5 investigation was required, although the Minute acknowledged that Ira would likely deny the allegations.<sup>2778</sup> The Minute was silent on Parker's allegations, which had seemingly fallen from the Department's consideration since they were last considered in December 2019. We note that we were only provided with a version of this Minute that had not been signed by Secretary Pervan; however, minutes of the 25 September 2020 Strengthening Safeguards Working Group meeting and a later 8 November 2020 Minute (discussed below) indicate that Secretary Pervan approved this September 2020 Minute and accepted the recommendation.<sup>2779</sup>

On or around 25 September 2020, the Department decided to delay putting Baxter's allegations to Ira. This decision was made in the context of the Department wanting information from Ira about allegations that he had raised about Lester (we discuss these allegations as they relate to Lester in Section 8.3).<sup>2780</sup> A draft statement was taken based on a meeting between People and Culture staff and Ira in late September 2020 but was not finalised until November 2020.

On the evidence made available to us, it appears that in or around October 2020, the Department rediscovered Parker's allegations.<sup>2781</sup> These were referred by the Department to Tasmania Police on 21 October 2020.<sup>2782</sup> The Department told us that, on 26 October 2020, five days after the Department's referral, Tasmania Police notified the Department that it had 'closed' the matter.<sup>2783</sup>

On 2 November 2020, Secretary Pervan was reminded of Parker's allegation against Ira in a Minute prepared by the Department and endorsed a recommendation that the

Department wait to put the allegations against Ira to him until it had a statement from Ira about the allegations against Lester, noting at this point the draft statement had not been finalised.<sup>2784</sup> The Department ultimately finalised this statement on 5 November 2020.<sup>2785</sup> We are unclear why it took more than two months to finalise Ira's statement.

A few days later, on 8 November 2020, Secretary Pervan decided, through a Minute he approved, to suspend Ira and commence an Employment Direction No. 5 investigation into Parker and Baxter's allegations against Ira, although the Minute lacked some detail about serious allegations of abuse. The Minute recommending this course of action:

- noted that Ira's restricted duties were ceasing, which would 'see him exposed to young people', although it also noted that, given additional controls at the Centre (such as closed-circuit television footage), it was considered lower risk that the abuse outlined in the allegations could occur today<sup>2786</sup>
- referred to media attention and scrutiny involving child sexual abuse matters, including *The Nurse* podcast, which had foreshadowed on 3 November 2020 that the Centre would be featured in its upcoming episode (due to be aired on 10 November 2020)<sup>2787</sup>
- noted the seriousness of the allegations and that the public would expect that the allegations would be fully investigated and that Ira would be removed from working with children and young people<sup>2788</sup>
- acknowledged the change in position from advice reflected in the September 2020 Minute (to put the allegations to Ira informally and seek his response) but referred to the fact that there were now multiple allegations that 'may suggest a pattern of inappropriate behaviour', stating 'what previously wasn't considered was the public expectation and pattern of behaviour'.<sup>2789</sup>

We were told that the decision to suspend Ira was made because there was, at that time, 'sufficient particulars' or information relating to the allegations against Ira that could be responded to.<sup>2790</sup> We note that the decision in November 2020 to suspend Ira and begin an Employment Direction No. 5 investigation was based on the same information that was known to the Department in September 2019. We discuss this briefing, alongside Lester and Stan's, in Section 9.6.

Ira was ultimately suspended from his employment at the Centre in November 2020, some 15 months after the Department became aware of Baxter's allegations. It was 18 months after Parker's allegations, although we accept that these alone may not have triggered an Employment Direction No. 5 investigation.

In February or March 2021, the Department appointed an external investigator to examine the allegations against Ira.<sup>2791</sup> Further allegations were made against Ira in 2021 and 2022 following his suspension and the start of the Employment Direction No. 5 investigation, raising concerns that are relevant to a pattern of physical and sexual abuse of children.<sup>2792</sup> We understand the investigation is ongoing.<sup>2793</sup>



## 8.2.2 Responses of Tasmania Police and the Registrar

We received conflicting evidence about when the Department reported Parker and Baxter's allegations to the Registrar. While the Department told us that it notified the Registrar about Baxter's allegations in August 2020 and Parker's allegations in October 2020, the Registrar gave evidence that it was only on 9 November 2020 that he received enough information about Parker and Baxter's claims to consider them notifications.<sup>2794</sup> Again, we note that the Department had been aware of these allegations since September 2019.

On 10 November 2020, the Registrar notified Ira that he intended to conduct an additional risk assessment to determine whether he should maintain his registration to work with vulnerable people.<sup>2795</sup> The Registrar did not suspend Ira's registration while this risk assessment occurred. We were told this was because there was not enough detail in the allegations.<sup>2796</sup>

Although the Registrar has received more information since this time (and at its request), as of 15 August 2022, the Registrar told us that he was awaiting 'further information as to investigations by the Department of Communities including receipt of all relevant information'.<sup>2797</sup> As of 11 August 2023, we understand that Ira still holds his registration to work with vulnerable people.

We reflect above the Department's evidence as to when it reported to Tasmania Police. This is inconsistent with some of the information received from Tasmania Police. For example:

- The Department told us that it reported Baxter's allegations to Tasmania Police in February 2020.<sup>2798</sup> However, Tasmania Police did not list this report in response to our request for all reports made against Ira.<sup>2799</sup>
- The Department told us that it reported Parker's allegation to Tasmania Police in October 2020.<sup>2800</sup> However, Tasmania Police's evidence suggests that it did not receive a report from the Department directly but rather from a third party, some eight months later, in June 2021.<sup>2801</sup>

There was also evidence of substantial delays in Tasmania Police reporting allegations to the Registrar. Parker's allegations were referred almost two years after the Department says it reported the allegations to police.<sup>2802</sup> We received no evidence that Tasmania Police reported Baxter's allegations to the Registrar at all.<sup>2803</sup>

Ultimately, Tasmania Police told us that it received three allegations against Ira and did not investigate any of these allegations given that the complainants were either deidentified in the source of the information or did not consent to being contacted by Tasmania Police.<sup>2804</sup>



## 8.3 Case example: Lester

Lester was one of many Centre staff members who began working at Ashley Home for Boys as a youth worker and continued his employment with the Centre until he resigned in the early 2020s.<sup>2805</sup>

### 8.3.1 Allegations against Lester

Multiple allegations of child sexual abuse were made against Lester from the early 2000s:

- In the early 2000s, there was an investigation into a complaint that Lester had exposed himself to detainees, although we note that the Department never told us directly about this allegation or investigation.<sup>2806</sup>
- From the late 2000s to early 2010s, four claims were made against Lester through the Abuse in State Care Program. The allegations included that Lester tried to rape a complainant, forced a complainant to perform oral sex, touched a complainant's penis and bottom during a strip search, watched a complainant while the complainant was masturbating, bribed a complainant with privileges to allow instances of child sexual abuse to occur, and watched a complainant in the shower and made sexual gestures towards him.<sup>2807</sup> We note that in two of these cases the sexual abuse allegations included associated allegations of physical abuse.<sup>2808</sup>
- In the early 2010s, a community member reported child sexual abuse by Lester outside the Centre to Tasmania Police, noting their concern that Lester worked with children at the Centre.<sup>2809</sup> Tasmania Police took a statement from the complainant who was described as 'unsure if [they] wanted to proceed to court proceedings'.<sup>2810</sup> Tasmania Police did not share this allegation with the Department.<sup>2811</sup>
- In the mid-2010s, the Department received information about a claim relating to Lester alleging child sexual abuse.<sup>2812</sup> The Department reported this allegation to Tasmania Police about two weeks later.<sup>2813</sup> Neither Tasmania Police nor the Department investigated this matter further, with Tasmania Police stating that the victim-survivor did not want to speak with police.<sup>2814</sup>
- In January 2020, as recalled by former Clinical Practice Consultant at the Centre, Alysha (a pseudonym), Ira told her that in the 1990s or early 2000s he had witnessed an incident in which Lester was standing with a naked child, who was on all fours in what was known as the Ashley Youth Detention Centre secure unit.<sup>2815</sup> Alysha reported the allegation directly to her line manager in the Department.<sup>2816</sup> We were not satisfied that this report was recognised as a report of potential child sexual abuse at the time of its receipt. We discuss Departmental views of this report in Case study 5. Departmental documentation from March 2022 suggested that Alysha's report 'does not provide information that would lead the reader to conclude without doubt a serious sexual assault and/rape was perpetrated', although the allegations were acknowledged as 'concerning information' that required further review.<sup>2817</sup>

- In September 2020, Tasmania Police also received an anonymous report that Lester sexually abused detainees over a 15-year period.<sup>2818</sup> The police disclosure report noted under the heading ‘Previous offences’ that ‘many children’ had alleged physical and sexual abuse by Lester.<sup>2819</sup>

### 8.3.2 Department’s response to the January 2020 report

Despite Alysha’s report in January 2020, the Department appeared to take no meaningful action in early 2020 in response to the allegation. We were told ‘extensive file searches’ were taken to determine whether information relating to the allegations was held on Lester’s file, which did not uncover any information about the allegation reported by Alysha (or prior Abuse in State Care claims against Lester).<sup>2820</sup> Although we were told these extensive file reviews occurred shortly after Alysha’s report, an email sent much later by Ms Clarke in September 2020 said it did ‘not appear that any investigation has been undertaken’ into Alysha’s report about Lester and that an ‘HR file review needs to occur’.<sup>2821</sup> In addition, an extensive file review is not a sufficient investigation. The Department did not meet with Ira to verify the information received from Alysha until September 2020.

In early 2020, after Alysha’s report, Lester acted in an operational role at the Centre, until he was redirected back to his substantive non-operational role based on site at the Centre in May 2020.<sup>2822</sup> The Department told us that, during the period from May 2020 until Lester’s resignation, Lester was in a non-operational role that did not have direct contact with detainees, although he remained on site at the Centre but separate from the main building.<sup>2823</sup> We heard allegations that Lester conducted a strip search of a detainee after Alysha made her report in January 2020, but no records documenting that strip search were identified by the Department.<sup>2824</sup> Some witnesses agreed that controls on Lester’s contact with detainees could have been stronger. Mr Watson told us it was his view that Lester should not have been on site in any capacity.<sup>2825</sup> Pamela Honan, Director, Strategic Youth Services, and Ms Baker conceded that the risk to children was not fully mitigated while Lester remained at the Centre. Ms Honan said: ‘Well, I wouldn’t say they [detainees] weren’t protected, but there was definitely a risk with this person still in the workplace’.<sup>2826</sup>

Ms Baker said:

I do note that there are other controls that would have existed, however [Lester] did remain in the workplace, albeit in a non-operational role ... and therefore the risk to young people at AYDC was not fully mitigated between January 2020 and when he was suspended from duty in November 2020. This is regrettable.<sup>2827</sup>

In September 2020, the Department finally met with Ira, despite Alysha reporting the allegation to the Department in January 2020. We remain unclear about the reasons for this delay, given a statement from Ira seemed the most obvious way to gather

more information as Ira was reportedly a direct witness to the incident. We were told that there were many ‘attempts’ to obtain his statement between January and May 2020.<sup>2828</sup> We received some evidence that suggested the delay was a result of Ira being on restricted duties and that he did not return to Ashley Youth Detention Centre until around the time that his statement was taken.<sup>2829</sup> This is contrary, however, to other evidence we received that Ira was still present at the Centre while he undertook restricted duties from September 2019, as discussed earlier. In any event, we are unclear why Ira’s absence from the Centre would have prevented him from making a statement to the Department about the allegations against Lester.

We were also told that, at the end of August 2020, Ms Clarke became aware of the allegations Alysha reported against Lester after a discussion with a private lawyer, who had been engaging with the Commissioner for Children and Young People about a ‘high number’ of allegations of sexual and physical abuse of detainees by staff.<sup>2830</sup> After this meeting, Ms Clarke spoke to staff and became aware of Alysha’s report. Ms Clarke made enquiries in the Department about Alysha’s report and requested a closer review of all information held by the Department about allegations of abuse by Centre staff (discussed in Section 9). It is not clear what information Ms Clarke obtained relating to Alysha’s report at the time.

It was only when Ms Clarke became aware of Alysha’s report that the Department seemingly reconsidered the report. An email from Ms Clarke (mentioned earlier) suggests that there was no investigation undertaken of Alysha’s report before this time, and we accept that evidence.<sup>2831</sup>

### 8.3.3 Rediscovering the Abuse in State Care Program claims

As noted, Ms Clarke’s meeting with a private lawyer prompted her to check historical records relating to allegations against staff at Ashley Youth Detention Centre.<sup>2832</sup>

In September 2020, the Department conducted a review of the Abuse in State Care Program claims to identify whether any serving Centre staff had been the subject of allegations (we discuss this review in Section 9.2). The four Abuse in State Care Program claims containing allegations against Lester were rediscovered through this review in September and October 2020.<sup>2833</sup> Ms Baker told us:

The information gathered from the Abuse in State Care Scheme would suggest prior matters which when put together with the matters that [Alysha] reported forms a more holistic picture of [Lester] and his alleged offending ...<sup>2834</sup>

### 8.3.4 Suspension and investigation

Ira’s statement was finalised on 5 November 2020.<sup>2835</sup> This allegation was then reported to Tasmania Police and the Registrar on 6 November 2020, some 10 months after the Department first received it.<sup>2836</sup> The Department also reported the Abuse in State Care Program allegations to Tasmania Police and the Registrar on 9 November 2020.<sup>2837</sup>

On 8 November 2020, Secretary Pervan decided to suspend Lester and commence an Employment Direction No. 5—Breach of Code of Conduct investigation into the allegation reported by Alysha and supported by Ira in his statement. While the Minute to the Secretary recommending this course of action also referred to three of the Abuse in State Care Program claims, the Secretary’s decision did not appear to be predicated on these allegations, with the Minute stating that the Department was trying to get more information about these claims.<sup>2838</sup> We are unclear why the Minute did not refer to the fourth Abuse in State Care Program claim. In any event, the decision taken at this time was based on the information provided to the Department some 10 months earlier.

We note the Minute stated that given additional controls at the Centre (including the use of cameras) there was a lower risk that the abuse could occur in the environment at the Centre today.<sup>2839</sup> However, the Minute also acknowledged that it may not have been possible to eliminate the risk, especially if Lester was in direct contact with detainees.<sup>2840</sup>

Correspondence to Lester notifying him of the Employment Direction No. 5 investigation and suspension also indicated that the Secretary could not identify alternative duties that would sufficiently mitigate the risk.<sup>2841</sup> This was even though some witnesses identified Lester’s non-operational role acting as a means by which the potential risks he posed to detainees were managed.<sup>2842</sup>

At some point after March 2021, an external investigator was appointed to conduct the Employment Direction No. 5 investigation into Lester.<sup>2843</sup> We understand that the Abuse in State Care Program allegations were added to the investigation. It appears that at least one of the allegations against Lester listed above was never added to the investigation.<sup>2844</sup>

A further five allegations relating to child sexual abuses were raised against Lester after his suspension, which came from a variety of sources.<sup>2845</sup>

Lester resigned from his employment in mid-2021.<sup>2846</sup> Shortly after, Secretary Pervan ceased the investigation into Lester’s conduct with no further employment action to be taken unless Lester began working with the State Service again.<sup>2847</sup>

### **8.3.5 Responses of Tasmania Police and the Registrar**

While the Department reported all four Abuse in State Care Program claims to Tasmania Police in November 2020, Tasmania Police referred these allegations to the Registrar some 21 months later in August 2022.<sup>2848</sup> Assistant Commissioner Higgins conceded at hearings that this was an oversight by Tasmania Police.<sup>2849</sup>

As set out above, the Registrar received information from the Department about Lester on 6 and 9 November 2020. On 10 November 2020, the Registrar notified Lester that he intended to conduct an additional risk assessment.<sup>2850</sup> The Registrar immediately suspended Lester’s registration at this time ‘due to the volume and gravity of the alleged conduct and the existence of some corroborating evidence’.<sup>2851</sup>

On 4 August 2021, Lester’s registration to work with vulnerable people lapsed before his additional risk assessment was finalised. Lester no longer holds registration under the Registration to Work with Vulnerable People Act.<sup>2852</sup>

## 8.4 Case example: Stan

Stan is a long-time Centre staff member who started working at what was then Ashley Home for Boys and held roles that involved engaging with detainees, until his suspension in November 2020.<sup>2853</sup>

### 8.4.1 Allegations against Stan

From the early 2010s, several former detainees alleged that Stan had abused them:

- In the early 2010s, a former detainee made a claim through the Abuse in State Care Program alleging that Stan physically abused him.<sup>2854</sup> It is unclear when the Department rediscovered this claim, but we infer that it did so through the review of the Abuse in State Care Program claims conducted in 2020, which we explain in Section 9.2.
- In 2017, a former detainee, Ben (a pseudonym), made a submission to the National Royal Commission into Institutional Responses to Child Sexual Abuse that alleged Stan had raped him and another detainee on three occasions.<sup>2855</sup> This submission was provided to Tasmania Police in 2017.<sup>2856</sup> It is unclear whether the Department was informed of the allegations in Ben’s submission in 2017. However, later exchanges between the Department and Tasmania Police indicate that Tasmania Police had thought that the Department had been aware of these allegations since around the time they were made.<sup>2857</sup>
- In or around early 2019, the Department was notified of allegations of sexual abuse made by a former detainee that named Stan. Due to human error (outside the Department) this allegation was only linked to Stan in October 2020.<sup>2858</sup> The Department referred these allegations to Tasmania Police on 21 October 2020.<sup>2859</sup> On 26 October 2020, five days after the Department’s referral, Tasmania Police notified the Department that it had ‘closed’ the matter.<sup>2860</sup> The Department told us that it referred those allegations against Stan to the Registrar on 21 October 2020, although the Registrar told us he first received this allegation about Stan on 26 May 2021.<sup>2861</sup>
- In mid-2020, the Department received a Letter of Demand from Ben which, in line with his 2017 submission to the National Royal Commission, included allegations that Stan raped him on three occasions.<sup>2862</sup> Despite receiving those allegations in mid-2020, the Department did not report the allegations to Tasmania Police or the Registrar until about three months later.<sup>2863</sup> We also saw little action taken

by the Department from the time of receiving this allegation in mid-2020 until Stan's suspension in November 2020, although we received some evidence that in September 2020 the Department cross-checked Stan's records in an attempt to corroborate the allegations.<sup>2864</sup> Much of the Department's evidence was that it was waiting on police advice before taking action in relation to Stan.<sup>2865</sup> We discuss this evidence, and our views on the extent to which the interaction with police processes influenced delays, later in this section.

- In September 2020, the Department received allegations raised by another complainant.<sup>2866</sup> The information alleged that Stan and several other staff members engaged in child sexual abuse but did not link any specific instance of abuse to Stan.<sup>2867</sup> That complainant had also raised allegations of sexual abuse while at the Centre through the Abuse in State Care Support Service in 2017, although they did not name any alleged abusers at the time.<sup>2868</sup> The Department reported these new allegations to Tasmania Police and the Registrar three weeks later, in October 2020.<sup>2869</sup>

On 3 November 2020, Tasmania Police advised the Department that certain complainants did not wish to make a statement.<sup>2870</sup>

#### 8.4.2 Department's response

Stan was suspended pending an Employment Direction No. 5—Breach of Code of Conduct investigation in November 2020.

The Minute to the Secretary recommending this course of action did not include all the allegations against Stan that are outlined above; it only noted Ben's allegation (contained in his Letter of Demand) and the allegation notified to the Department in September 2020.<sup>2871</sup>

We note the Minute stated that Stan had direct contact with detainees through his role.<sup>2872</sup> The letter to Stan notifying him of his suspension and intended Employment Direction No. 5 investigation also stated that Secretary Pervan could not find alternative duties for Stan that sufficiently mitigated the risk that was present in the allegations.<sup>2873</sup> We note that the Department told us that the risk posed by Stan remaining in the workplace was mitigated because he was in a building not accessed by detainees, and that the Centre Manager was made aware of the allegations so he could remain vigilant.<sup>2874</sup> We also saw evidence that the Centre Manager was raising concerns about Stan continuing to work on site with children.<sup>2875</sup> The Minute leading to Stan's suspension is discussed in Section 9.6.

On 12 February 2021, Secretary Pervan appointed an external investigator to examine the allegations against Stan.<sup>2876</sup> The other allegations made against Stan, including the earlier Abuse in State Care Program claim, were added to the investigation at this time.<sup>2877</sup>



A further three claims (two of which involved allegations of child sexual abuse) were raised against Stan following his suspension and the start of the Employment Direction No. 5 investigation.<sup>2878</sup> We understand the investigation is ongoing.<sup>2879</sup>

### 8.4.3 Response of Tasmania Police and the Registrar

As was the case with Ira and Lester, we received evidence that there were substantial delays in Tasmania Police reporting allegations to the Registrar. For example, while allegations against Stan raised directly with the Department in 2021 were reported to Tasmania Police in 2021, the police did not report this to the Registrar for some nine months.<sup>2880</sup> Also, we received evidence that despite receiving Ben's National Royal Commission submission in 2017, Tasmania Police did not report the allegations to the Registrar through its automated referral process.<sup>2881</sup> Assistant Commissioner Higgins agreed that this is an example of how the process is subject to 'human error'.<sup>2882</sup>

Ultimately, Tasmania Police told us that it received four allegations against Stan.<sup>2883</sup> The evidence indicates that Tasmania Police had also been notified by the Department of at least one further allegation against Stan.<sup>2884</sup>

The Registrar began an additional risk assessment into Stan on 18 September 2020, having received Ben's allegations against Stan on that day.<sup>2885</sup> The Registrar did not suspend Stan's registration pending the outcome of the additional risk assessment.<sup>2886</sup>

After receiving more allegations from the Department, the Registrar sent Stan a letter in April 2021 with notice of his intention to suspend Stan's registration to work with vulnerable people.<sup>2887</sup> More allegations and updates were provided to the Registrar, after which the Registrar proposed to cancel Stan's registration in February 2022.<sup>2888</sup> The Registrar's written reasons stated that Stan had been named as a 'responsible person for abuse by five separate alleged child victims', and that the allegations 'are those of the most serious kind and are directly relevant to [Stan's] eligibility to maintain registration'.<sup>2889</sup> Also, the written reasons stated that given the number of allegations raised over a lengthy period, it was reasonable to conclude that a pattern of behaviour was present.<sup>2890</sup>

However, after further engagement with the Department and Stan, the Registrar ultimately decided to continue Stan's registration in July 2022.<sup>2891</sup> There was a stark difference between some of the reasoning provided in the Registrar's proposed and final decisions, with the Registrar concluding in the final decision that it was not possible to identify a pattern of grooming or offensive behaviours.<sup>2892</sup> The Registrar also considered the claimants' histories of criminal offending, calling their credibility into question.<sup>2893</sup> As we have noted throughout this chapter, we received no evidence to support a conclusion that detainees had made false allegations for malicious or financial gain, nor did we find evidence that former detainees had colluded in making allegations. Indeed, collusion between former detainees was unlikely given the allegations spanned more



than a decade. We did receive evidence from former detainees that they believed their criminal histories meant they were less likely to be believed. We make a recommendation on factors to be considered in the Registrar’s risk assessment in Chapter 18.

As of 11 August 2023, Stan continues to hold registration to work with vulnerable people.

## 8.5 Enduring themes we saw in our case examples

We identified a range of problems in responses to our case examples of Ira, Lester and Stan that meant allegations of serious abuses were not acted on quickly and effectively. This had the practical effect of placing detainees at risk of harm because staff who were the subject of serious allegations remained at the Centre. We were disappointed to see that many of these problems were also apparent in our case example of Walter, discussed in Section 6.2.

### 8.5.1 Delays in notifications

Across the three case examples we explored, we saw significant delays by the Department in reporting allegations to Tasmania Police and the Registrar. Examples include the following:

- The Department’s notifications to Tasmania Police of Baxter and Parker’s allegations against Ira were made around five and 18 months, respectively, after the Department became aware of the allegations.<sup>2894</sup>
- The Department first raised Baxter’s allegations against Ira with the Registrar on 11 August 2020.<sup>2895</sup> However, it was not until 9 November 2020 that the Department could provide enough information to the Registrar about Baxter’s allegations for the Registrar to consider it a notification of reportable behaviour.<sup>2896</sup>
- In relation to Lester, the Department only passed on Alysha’s report to Tasmania Police and the Registrar in November 2020, despite being received around 10 months earlier in January 2020.<sup>2897</sup>
- In relation to Stan, the Department only reported Ben’s allegations to Tasmania Police and the Registrar in September 2020, despite being received in mid-2020.<sup>2898</sup>

We consider there are a range of reasons that contributed to delays in making those notifications, including:

- confusion and a lack of clarity around whether and when certain matters should be reported to the Registrar (we discuss the legislative ambiguity around this in Section 3.1.2), which the Department resolved in September 2020 (described in Section 9.3)
- failures to identify certain conduct as amounting to potential child sexual abuse—we consider this to be a contributing factor for the delay in responding to Alysha’s report about Lester

- poor record keeping, which made it difficult to locate and share relevant information quickly
- perceived barriers to information sharing about child safety—seeking legal advice, adopting a narrow interpretation of reporting obligations and often only reporting where required by law.

We acknowledge that we do not discuss mandatory reporting to Child Safety Services in detail in this case study. We note, however, that Child Safety Services were not notified about any of the allegations we examined in our case examples. While we note the confusion when complainants were adults and risks related to a group rather than an individual child, we consider it would have been best practice to report, as we have made clear throughout this case study.

The safety of children in institutions depends on all parties sharing what they know with other relevant agencies quickly and accurately and applying good judgment about what should be shared, even if such sharing is not mandated. It is information that is ultimately the basis upon which decisions are made and, in the context of child safety, should be treated and shared with the care and safety of children and young people at the forefront. It is critical that agencies such as Tasmania Police, the Registrar and Child Safety Services receive information relevant to their functions at the earliest opportunity to enable swift action.

We are pleased that in much more recent cases we examined in 2022 (the themes of which are discussed in Section 14.1) the timeliness of notifications has significantly improved.

### 8.5.2 Deficient record keeping

Across our case examples, we observed the challenges that the Department's deficient record-keeping practices presented. We were told poor record keeping made it difficult for the Department to access relevant records and contributed to delays in responding to allegations of child sexual abuse.<sup>2899</sup>

These problems also affected former detainees seeking information. For example, Ben told us of the difficulties he has faced in accessing information about his time in detention:

I have applied to get a copy of my Ashley file three times, including twice while I was still in prison. All I've ever received in response to my requests are a few pieces of paper. There should be so much more. There would be hundreds of incident reports on my file, with many of them detailing violent incidents with workers ...<sup>2900</sup>

Departmental officials were frank about the poor record-keeping practices at Ashley Youth Detention Centre. We were told that Centre records were paper based, stored in various locations, poorly catalogued or indexed, and not easily accessible.<sup>2901</sup> We heard

about ‘an entire room the size of a garage full of paper files that went back for years and years and years’ and that records were sometimes only discovered ‘incidentally’.<sup>2902</sup>

We were told that due to these record-keeping practices, it was difficult for the Department to establish facts, timeframes and key events relating to the allegations.<sup>2903</sup> Records had not been catalogued or indexed, so accessing relevant information for preliminary assessments and during the investigation was time-consuming and labour-intensive.<sup>2904</sup> We understand this extended to even relatively basic matters, such as confirming that a complainant was at Ashley Youth Detention Centre at a particular time, or that an employee worked at the Centre at the time of an allegation.<sup>2905</sup> The lack of access to reliable, well-indexed catalogued records was described as a ‘limiting factor’ in undertaking preliminary assessments more quickly.<sup>2906</sup> It also had a major impact on the Department being able to thoroughly investigate, and act on, allegations it received and meant that senior managers and the Secretary did not have a complete picture of all the allegations that may have been made about a particular staff member.

Ms Baker said that it became clear to her in late 2020 or early 2021 that the Department was ‘severely hampered’ in its ability to respond and produce information for the Registrar and in the context of Employment Direction No. 5 investigations.<sup>2907</sup>

We discuss the Department’s records remediation project in Section 13.2 and make more observations and recommendations about records in Chapter 12.

### **8.5.3 Lack of awareness and responsiveness to Abuse in State Care claims**

Abuse in State Care Program claims contained critical information that was directly relevant to potential risks posed by staff and yet there was no meaningful process to enable the Tasmanian Government and other agencies to act on it. The practical result of this was that the program itself faded from the Department’s corporate memory and the valuable information contained in claims was essentially lost. When reporting obligations to the Registrar arose in 2015, with retrospective effect, this information was not revisited for reporting purposes, even though the Abuse in State Care Support Service (the successor to the Abuse in State Care Program) continued—and continues—to operate.

Earlier in this case study, we made a finding that from 2007 onwards, the Department should have taken more active steps to protect children from potential risks posed by staff who had allegations of abuse made against them through state redress schemes. In that finding, we highlight the introduction of the Registration to Work with Vulnerable People Scheme as a particular opportunity to address a key gap in managing risks posed by staff and volunteers in institutions. If the Department and Tasmania Police had done this on the establishment of the scheme in 2015 for Lester, for example, there would have been four Abuse in State Care Program claims, one Abuse in State Care Support Service claim (which had a related police report) and one standalone police complaint referred

to the Registrar. The allegations included those of forced oral sex, attempted rape, masturbating in front of detainees, bribery for sexual acts and watching detainees while they showered or masturbated. The Registrar could have used this to assess Lester's suitability to retain registration to work with vulnerable people many years ago. Had there been stronger record keeping for complaints arising from Lester at Ashley Youth Detention Centre before 2008, there may have been even more information available.

As acknowledged above, the Department received several allegations of abuse relating to serving Centre staff through the Abuse in State Care Program and the Abuse in State Care Support Service. Seven Abuse in State Program claims named Lester or Stan, but there were many more relating to Ashley Youth Detention Centre. Taken together, they reflect an alarming pattern of alleged behaviour among some long-serving staff members.

As we describe in Section 9.2, these complaints histories only began to be pieced together in mid-2020 when newer departmental staff became aware of the program and recognised the significance of the information in these claims. While this was an important and welcome development, it came many years too late.

We acknowledge the evidence we received about the barriers the 2007 Solicitor-General's advice (and related practice) created in acting on information received through the Abuse in State Care Program. As we describe in our earlier finding, however, we consider this practice should have been revisited and revised (as it eventually was in December 2020, described in Section 9.8) in the interests of promoting children's safety and the public interest.

#### **8.5.4 Inadequate risk management in response to information about Centre staff**

Across all case examples, including that of Walter, we found a failure to recognise allegations for what they were or had the potential to be: allegations of child sexual abuse. Unlawful strip searches (such as those that involve touching or gratuitous nudity, or are not based on reasonable grounds), the touching of children's genitals outside legitimate medical treatment by a health practitioner, invasions of privacy that constitute voyeurism (such as observing detainees masturbating)—are allegations of child sexual abuse.

We saw what appeared to be reluctance from the Department to characterise Alysha's report about Lester as potential child sexual abuse, with a tendency to downplay the allegation as inappropriate or concerning conduct. This was similar to the way Erin's complaint about Walter's invasion of her privacy while she was showering was seen—as a gender insensitivity issue rather than a potential sexual violation. We discuss the Department's reluctance to characterise Alysha's report as a report of child sexual abuse in Case study 5.

Staff need to understand what may constitute child sexual abuse and related conduct, particularly in the early stages of receiving an allegation. While sometimes allegations

can seem relatively benign on the surface, more information and context can point to something far more troubling. Failure to understand the nature of allegations compromises the quality of risk assessments.

We saw other weaknesses in how potential risks to detainees were managed, with staff the subject of serious allegations remaining on site and with the potential to interact with detainees. We consider:

- Relying on Ira's restricted duties (arising from circumstances unrelated to the allegations against him) was inadequate because it was not specifically directed at preventing his contact with detainees.
- Relying on Lester moving into a role that did not involve direct contact with detainees as a safeguard was inadequate given he remained on site, was at least occasionally called on to assist in operational matters, and held different roles in an acting capacity, during which he was alleged to have conducted a strip search.
- Not modifying Stan's role or removing him from the Centre was inappropriate given his role involved significant contact with detainees.

The 8 November 2020 Minutes recommending the suspension of Ira, Lester and Stan (described in Section 9.6) make it clear that, despite the cited safeguards, Lester and Stan continued to have contact with children.

We heard of other inadequate risk mitigations. For example:

- The Department told us its risk mitigation strategy for dealing with certain allegations against Stan was that Mr Watson was 'made aware of allegations received [in late 2020] so he could remain vigilant, whilst police [undertook] their enquiries'.<sup>2908</sup> This was some three months after the Department received Ben's allegations against Stan.<sup>2909</sup>
- In the case of Ira, Mr Watson (then Acting Centre Manager) told us he only became aware of the allegations against Ira incidentally in March 2020, four months after the Secretary was first briefed on the allegations.<sup>2910</sup>
- In relation to Lester, Patrick Ryan, who was the Centre Manager in January 2020 when Alysha made the report, told us at our hearings that he learned of the allegations against Lester through our Commission of Inquiry.<sup>2911</sup> Reflecting on his lack of knowledge of previous allegations against Lester, Mr Ryan said 'it is something I should have known, something I should have been advised of'.<sup>2912</sup>
- Mr Ryan told us that he was also not told of any restrictions that should be placed on Lester's access to young people and, in fact (not knowing about the allegations) encouraged Lester and others to 'get out of their offices and walk around the centre, support each other, support the young people, build relationships'.<sup>2913</sup>

He told us:

... if I was aware of [the allegations] at the time I would have— I wouldn't have encouraged Lester's contact with young people, there would have needed to have been some intervention.<sup>2914</sup>

We consider that Centre managers were not able to put in place and enforce appropriate risk mitigations given they were not advised of allegations against staff at the earliest opportunity.

We also saw the Department adopt a position that deferred to police action and justified this as a reason not to take immediate protective action. This was particularly noticeable in the context of the response to Stan but was also seen in other case examples.

The evidence we received about acting on allegations of abuse by Stan was that the Department was waiting on police advice before taking disciplinary action.<sup>2915</sup> Yet, the Department became aware of the allegations in mid-2020, but did not report them to Tasmania Police until approximately three months later and did not suspend Stan until 8 November 2020.<sup>2916</sup>

Assistant Commissioner Higgins gave evidence that the way Tasmania Police and the Department work together has improved, saying:

I honestly think this [collaboration] is done far better now with everything that the government agencies have done to improve in reporting and working together, particularly in relation to criminal matters and [Employment Direction No. 5 investigations]; I think that hasn't always been the case ... but I think it's fair to say that over the last couple of years in particular that has certainly changed, for the better for all.<sup>2917</sup>

We accept that consultation and cooperation with Tasmania Police is important, but this should not come at the expense of child safety and can be achieved concurrently. Appropriate risk mitigations may need to be designed to address specific risks posed by alleged abusers to remove their access to children while an investigation progresses. We discuss this in Section 10.5.

At times, relying on Tasmania Police's actions suggested confusion over the test required to progress a criminal matter with that required to progress a disciplinary matter.

### **8.5.5 Conservative application of the State Service disciplinary framework**

Throughout our Inquiry, we identified several challenges associated with applying the State Service disciplinary framework to child sexual abuse and related conduct. These reflect systemic problems across the State Service, which we discuss in Chapter 20.

We were told about the difficulties the Department faced in responding to allegations of child sexual abuse against staff, attributing this to the employee-focused requirements of the disciplinary process. We heard evidence to suggest some within the Department

feared that employees might challenge decisions to initiate investigations in the Tasmanian Industrial Commission. Such concerns were reflected in some of the meeting minutes and advice to the Secretary that we reviewed.<sup>2918</sup> Ms Baker said:

The Employment Framework in the State Service facilitates employees reviewing decisions. Section 50 of the *State Service Act 2000* provides for employees to be able to review decisions related to their employment (with the exception of termination). In my view, this has naturally led to a very considered approach for decision making being adopted and is a contributing factor for some ED5s [Employment Directions No. 5] taking some time to commence, following the receipt of initial information. In undertaking an initial assessment, you seek to gather the relevant pieces of information for two key reasons. Firstly, to enable the decision maker (the Secretary of Communities Tasmania) to form a reasonable belief (as is required by ED5) that a breach may have occurred. Secondly, to frame up the allegations that you intend to put to the employee. If the allegations aren't descriptive enough, it is not providing the employee the opportunity to be able to consider and respond. If this eventuates you may end up with a review of decision, which could compromise the continuation of ED5.<sup>2919</sup>

Ms Clarke told us that while the Department's paramount consideration was the safety of young people in detention, she also:

... recognised the importance of balancing the paramount consideration with the need for an initial assessment to be undertaken that would support a plausible allegation when/if subjected to industrial scrutiny.<sup>2920</sup>

Secretary Pervan told us that the industrial and employment lens meant that issues of natural justice to the employee were given primacy over the issue of child safety.<sup>2921</sup>

We saw some issues arising in the context of responses to Ira, Lester and Stan including the following:

- Oral briefings were relied on to brief to the Secretary about allegations against staff, with written material provided in a formal briefing many months later as part of the preliminary assessment process. This informality and lack of consistency also meant oral briefings were not documented.
- There also did not appear to be a clear escalation process, with identification of which role-holders were responsible for which actions, and within a set timeframe.
- Responses did not comply with best practice guidance for preliminary assessments. The timeframes for the Department's preliminary assessments of allegations were lengthy—well beyond the three working days recommended by the Integrity Commission.<sup>2922</sup> In relation to Ira, Lester and Stan, we saw what would best be described as preliminary investigations drag out for months (and in Ira's case, for more than a year). It was unclear at times what exactly was occurring



in those months—sometimes, on the evidence we received, very little. But what activity was described to us (extensive attempts at validation and corroboration of specific details, the interviewing and statement preparation of witnesses) went far beyond what we consider necessary for a preliminary investigation and unnecessarily delayed appropriate action. We consider the interviewing of witnesses and the taking of statements (as occurred in relation to Lester) to be more appropriately undertaken by an independent investigator.

- The protracted and involved nature of the preliminary assessment process applied by the Department suggested a very high threshold for launching a disciplinary investigation, by essentially becoming an investigation within itself. There appeared to be significant concern about the need to bring concrete and substantial evidence to the Secretary, despite the test imposed by Employment Direction No. 5—Breach of Code of Conduct that a Head of Agency need only have reasonable grounds to believe a breach of the Code *may* have occurred. It is then a matter for an investigation to determine whether the matters can be substantiated.
- The Department adopted informal practices of ‘putting allegations’ to alleged abusers for a response. Secretary Pervan told us that this practice occurs primarily where there is a lack of information and that he considers the approach appropriate in those circumstances.<sup>2923</sup> We are concerned that this option was considered in each of the cases we reviewed given the nature and number of serious allegations.
- The Department was reluctant to consider the cumulative impact of allegations. As we describe in more detail in Section 9.6, we consider there was not enough weight placed on a potential pattern of behaviour that the fuller complaints histories revealed, particularly in relation to Lester. This was partly due to delays in piecing together all relevant information (such as Abuse in State Care Program claims) but, even when this occurred, we found the fact there were multiple complaints was not emphasised or consistently taken into account for disciplinary investigations.
- Industrial pressures created challenges in responding to allegations. We heard that, while detainee safety was the most important consideration, concern about the possibility of industrial scrutiny also weighed on the Department.

We make a range of recommendations to improve disciplinary responses in child sexual abuse matters in Chapter 20, and recommend that, in future, such matters be referred to a Child-Related Serious Incident Management Directorate for specialised response (refer to Recommendation 6.6 in Chapter 6).

## **Finding—The Department did not take appropriate steps to manage risk, make appropriate notifications and progress investigations against Ira, Lester and Stan (all pseudonyms), which left children and young people at Ashley Youth Detention Centre at potential risk of harm**

At various points between 2019 and 2020, it became clear to the Department that there were serious allegations of child sexual abuse made against Ira, Lester and Stan. We consider these allegations were not treated with the seriousness, urgency and care that was warranted. This had the effect of delayed reporting to relevant bodies and delayed disciplinary action, including the removal of staff from the Centre while a proper disciplinary process was conducted. These delays placed detainees at potential risk of harm in one of the highest risk environments for sexual abuse.

We consider these delays were a result of:

- limited understanding of the range of behaviours that constitute child sexual abuse
- concerns about privacy and sharing information with appropriate authorities
- deficient record keeping
- a corporate loss of knowledge of the Abuse in State Care Program
- a failure to consider the cumulative effect of allegations
- inadequate risk management strategies, including retaining staff on site, inappropriately relying on staff being in non-operational roles, not informing managers about potential risks and deferring action awaiting police direction
- conservative and narrow disciplinary processes, which ultimately gave preference to employee rights at the expense of child safety considerations.

Ideally, we would like to see the following:

- Allegations made against staff must be treated with seriousness and urgency, with relevant senior managers and the Secretary notified (ideally in writing). This requires an understanding of what constitutes child sexual abuse and sexual misconduct (particularly around issues such as strip searches or observing showers).
- Immediate notifications must be made to relevant key agencies, including Tasmania Police, the Registrar and Child Safety Services. Clear information-sharing channels should be established with these bodies so any more information and developments can be shared quickly with the right people in those agencies who are empowered to act.

- There needs to be immediate risk mitigation planning, including with managers at the Centre, to address potential risks to detainees. These mitigations should be tailored and proportionate to the potential risks and clear to all relevant managers and senior managers to ensure they can be monitored and enforced.
- Prompt preliminary assessments should draw on clear, accurate and accessible records that are available to the Department. Advice to the Secretary should place significant weight on the safety of detainees and reflect the relatively preliminary nature of the process (that is, not require extensive evidence or corroboration, which is more appropriately gathered through an independent investigation). The availability of potential witnesses could be canvassed and confirmed (for example, Ira in the matter of Lester) quickly as part of this preliminary assessment, but statements should be taken by the investigator at the next stage, during the Employment Direction No. 5 investigation.
- Sensitive and timely contact and engagement should take place with potential victim-survivors (where appropriate) to gauge their willingness to participate in investigations and to ensure they have appropriate support.
- All steps taken should be thoroughly documented.

## 9 Mid-2020 onwards—A change in the Department’s approach

By 2020, the number of National Redress Scheme claims relating to Ashley Youth Detention Centre was beginning to mount. By mid-2020, the Department had received allegations against Ira, Lester and Stan at various times (and through various means). During 2020, the Department was notified of nine National Redress Scheme claims containing allegations against Ashley Youth Detention Centre staff.<sup>2924</sup> Some of these claims contained several allegations against multiple staff members and the conduct was alleged to have occurred between 1995 and 2012.<sup>2925</sup> Also, two civil claims were issued against the Department in 2020 relating to allegations of abuse by Ashley Youth Detention Centre staff between 1998 and 2006.<sup>2926</sup> This escalation in allegations received against staff was a significant challenge for the Department, with many of the allegations relating to serving staff members.

On 30 January 2020, the World Health Organization declared the coronavirus (COVID-19) a Public Health Emergency of International Concern.<sup>2927</sup> On 17 March 2020, the then Premier of Tasmania announced that the State would take several public

health emergency response measures.<sup>2928</sup> As we have noted earlier, we recognise that responding to the pandemic was a significant challenge for the Department and Tasmanian Government more broadly in the months before and after March 2020.

During this period, we also saw a significant growth in the knowledge and understanding of the Abuse in State Care Program among senior departmental officials and the fact that many of these past claims related to current Ashley Youth Detention Centre staff, who were also being identified through National Redress Scheme claims. This was alluded to in some of our summaries in Section 8 because it occurred while the Department was responding to allegations against Ira, Lester and Stan.

We saw a range of efforts and measures within the Department in mid to late 2020 to improve its responses to allegations of abuse. These included the Department:

- establishing the Strengthening Safeguards Working Group in September 2020 to facilitate coordinated responses to allegations against staff
- undertaking a cross-check of Abuse in State Care Program files against a list of current employees from September 2020
- compiling a spreadsheet of Centre staff named in the Abuse in State Care Program, National Redress Scheme and common law claims in October 2020
- setting up a process and guidance for responding to ‘National Redress Scheme – Request for Information’ forms that contained allegations against serving employees, including involving the Deputy Secretary of Children and Youth Services in approving these forms from around September 2020
- clarifying and improving processes for reporting matters to Tasmania Police and the Registrar between August and September 2020
- obtaining updated legal advice from the Solicitor-General on how it could use information in redress and other claims to support disciplinary investigations in December 2020.

This section takes us to the time the Department was in the midst of responding to increasing allegations against staff, including Ira, Lester and Stan, under increasing pressure as awareness of the nature and scale of potential abuses began to grow. We have arranged this timeframe in a broad chronology.

## 9.1 September 2020—Strengthening Safeguards Working Group established and meets regularly

In September 2020, the Department convened a Strengthening Safeguarding Executive Working Group to discuss active employment matters at Ashley Youth Detention Centre.<sup>2929</sup> Witnesses referred to ‘case conferencing’, the ‘AYDC Working Group’ and the ‘Strengthening Safeguards Working Group’ interchangeably.<sup>2930</sup> For simplicity, we have adopted the term ‘Strengthening Safeguards Working Group’ throughout this report.

Members of the Strengthening Safeguards Working Group included Ms Clarke, Ms Baker, Ms Allen, Ms Honan, the Director of People and Culture and a legal adviser to the Department.<sup>2931</sup> Other people, such as the Centre Manager, attended particular meetings. Mr Watson was a regular attendee from late October 2020.<sup>2932</sup>

The Strengthening Safeguards Working Group met for the first time on 18 September 2020.<sup>2933</sup> Meetings were scheduled fortnightly, but we understand the frequency varied depending on the number of allegations or claims of abuse and their progress.<sup>2934</sup>

We were told that the purpose of the Strengthening Safeguards Working Group was to ensure coordination between departmental officers involved in civil and redress matters, including operational staff such as Ms Honan, so the People and Culture team could provide progress updates and share information on relevant departmental personnel matters and investigations.<sup>2935</sup> We received evidence that the meetings were used as an opportunity to:

- discuss the Department’s response to allegations of child sexual abuse against employees<sup>2936</sup>
- assist the Secretary to make decisions about suspending employees and commencing Employment Direction No. 5 investigations<sup>2937</sup>
- discuss options to direct staff to not have contact with children or putting staff on alternative duties<sup>2938</sup>
- raise other concerns, including about the delays in progressing action to suspend employees.<sup>2939</sup>

Secretary Pervan did not attend Strengthening Safeguards Working Group meetings. Ms Clarke recalled that she ‘would keep the Secretary abreast of ... new practices being implemented to mitigate risks’, which included action items identified by the Strengthening Safeguards Working Group.<sup>2940</sup> We understood her evidence to be that these updates would form part of fortnightly meetings with the Secretary and other more ad hoc engagement.<sup>2941</sup> Secretary Pervan told us he had ‘no hands-on involvement in the Strengthening Safeguards Working Group’ and could not recall any briefings relating to the group or any detail about actions it took.<sup>2942</sup>

We understand that the Strengthening Safeguards Working Group met between four and six times to the end of 2020 (noting its role continued into 2021).<sup>2943</sup> We have reviewed meeting minutes for the first four meetings and some associated file notes and correspondence, noting the following common themes or concerns across those meetings:

- There was a lack of clarity about the nature and number of allegations concerning Ashley Youth Detention Centre staff and the need for further information to understand the extent of allegations.<sup>2944</sup> Despite this lack of clarity, at least some staff were expressing concerns about the safety of children at the Centre, an apparent pattern of behaviour across allegations, and risk that potential child sexual abuse offenders were on site.<sup>2945</sup>
- There was no ‘clear co-ordinated process’ to respond to those claims made through redress or civil processes, including confusion about reporting responsibilities, such as to Tasmania Police.<sup>2946</sup>
- There was concern about the Department being subject to parliamentary or public scrutiny over the handling of the allegations against current staff members, should it become known that Centre staff had outstanding serious allegations against them.<sup>2947</sup>
- There was concern about a looming class action brought by several former Ashley Youth Detention Centre detainees alleging a range of harms and abuses.<sup>2948</sup>
- There were concerns about the potential ‘HR issues’ if staff were to be dismissed, including the need to ensure procedural fairness for employees, the risk that relevant staff may go to the Tasmanian Industrial Commission and concerns for staff morale at the Centre.<sup>2949</sup>
- Members deferred to police advice before engaging in disciplinary action (although there seemed to be some confusion about the extent to which suspension could begin without police clearance).<sup>2950</sup>

These issues mirror many of the themes we describe in Section 8.5.

From the establishment of the Strengthening Safeguards Working Group in September 2020, we began to see Department and Centre managers raise concerns about alleged abusers remaining on site at the Centre. Those concerns included comments about risks to the Department. We also began to see increasing concern from Department staff about the legal and moral implications of the Department not acting.<sup>2951</sup> In particular, one staff member with legal training raised questions with People and Culture about the Department’s apparent inability to start disciplinary investigations in the absence of a participating complainant or sworn statement, despite that imposing a higher threshold than that which applied to a civil claim.<sup>2952</sup>

## 9.2 August and October 2020—Awareness of the Abuse in State Care Program within the Department grows and information starts to be pieced together

We observed that knowledge among senior departmental officials about the Abuse in State Care Program was piecemeal and often came about by chance, even though:

- many allegations had been raised against Ashley Youth Detention Centre staff through the Abuse in State Care Program
- Secretary Pervan personally signed off on the *Review of Claims of Abuse of Children in State Care Final Report* in September 2014, which identified 172 claims made between 2011 and 2013 against Ashley Youth Detention Centre or its predecessor, Ashley Home for Boys<sup>2953</sup>
- the Department was the custodian of the Abuse in State Care Program records and used these materials to respond to National Redress Scheme requests for information.<sup>2954</sup>

We were told that only in August or September 2020 did some senior departmental officials and their advisers become aware—or more fully aware—of the Abuse in State Care Program and that allegations had been raised through this program against staff who were still employed at Ashley Youth Detention Centre.

Ms Clarke, then Deputy Secretary for Children, Youth and Families, acknowledged she was ‘aware of the concept’ of the Abuse in State Care Program (and had approved some ‘National Redress Scheme – Request for Information’ forms referring to the program in 2019).<sup>2955</sup> However, as mentioned, she told us she was prompted to consider the program in more detail following a meeting with a private lawyer in August 2020 about abuse allegations against staff.<sup>2956</sup> We note that it would have been clear from the forms that Ms Clarke approved in 2019 that allegations had been raised against employees, including through the Abuse in State Care Program.<sup>2957</sup>

In mid to late-2020, a legal adviser to the Department assumed responsibility for a period for overseeing responses to the National Redress Scheme information requests.<sup>2958</sup> As part of this process, they realised there was a possibility that some current employees may have been the subject of past Abuse in State Care Program claims.<sup>2959</sup> This awareness led to others learning of the Abuse in State Care Program incidentally. For example, Ms Allen learned about this through a passing comment from the legal adviser; Ms Baker found out because her office was located close to the legal adviser’s.<sup>2960</sup>

Ms Allen had begun working at the Department six to eight weeks before becoming aware of the Abuse in State Care Program. She told us that, up until that point, she had no knowledge of the program and had only been told of two unrelated Employment



Direction No. 5 investigations that were nearing completion.<sup>2961</sup> We were concerned by the lack of a formal briefing to Ms Allen on these matters when she first took up her role.

Ms Allen said ‘it was one of those, “Wait, wait, wait, hold up, what are you talking about? We have got all of this information that has never been put together and no action’s been taken”’.<sup>2962</sup> She went on to say:

It’s my understanding at that point in time that the four rounds of the abuse in state care applications were never put together to paint a picture of who may have been perpetrators of child sexual abuse, and ... it remains a very big disappointment of mine that that work hadn’t occurred prior, because I do believe that, putting to one side issues with advice that had been provided, there was definitely valuable intelligence a long time ago in relation to potential perpetrators of child sexual abuse; and it wasn’t until, again, the support of the executive that those files were got out and put together and to create a bit of that picture, a true picture, I believe, as to what may have occurred at Ashley was able to be painted.<sup>2963</sup>

We agree that the failure of the Department to use the information on those records reflected a critical missed opportunity to identify and address the potential risks posed by staff.

The growing awareness of abuse allegations connected to Ashley Youth Detention Centre was followed by a series of steps to consolidate the Department’s knowledge of the extent of abuse allegations and to coordinate a response. We were pleased to see these steps begin in August/September 2020, as this reflects an appropriate shift in approach by the Department. We summarise those steps below.

### **9.2.1 September 2020—A cross-check of Abuse in State Care Program records against current staff lists begins**

In or around September 2020, at Ms Clarke’s request, the Department began a ‘cross check’ of the names of alleged abusers in Abuse in State Care Program records against a list of current Ashley Youth Detention Centre staff who had been working at the Centre before 2010.<sup>2964</sup> We are unclear why this date threshold was imposed, which we note below. The review was also to identify what actions may have been taken where an employee had been named in an Abuse in State Care Program claim.<sup>2965</sup>

This cross-check did not cover all sources of potential information held by the Department. Specifically:

- It was limited to Abuse in State Care Program records and did not extend to allegations raised through the Abuse in State Care Support Service (the program’s successor from 2015).<sup>2966</sup>
- It was limited to serving employees who had been working at Ashley Youth Detention Centre prior to 2010. However, the Abuse in State Care Program ran until 2013, and we are aware that the period of abuse that was raised in Abuse in State

Care Program records spanned 1995 to 2013 (although, as set out in Case study 1, the period of abuse may have spanned a much longer period).<sup>2967</sup> This suggests the cross-check may not have captured employees who had been employed after 2010 and who were the subject of allegations regarding conduct that was alleged to have occurred between 2010 and 2013. We accept that many staff at the Centre had been employed before 2010.

- The process only considered claims relating to current Ashley Youth Detention Centre staff and not other people who were the subject of allegations (including other State Service employees, foster carers or people who were registered to work with vulnerable people) who may have also posed a potential risk to children. We discuss our concerns about the scope of the Department’s reviews of claims in Chapter 12.

We understand the cross-check work was completed around December 2020.<sup>2968</sup>

### **9.2.2 September 2020—Spreadsheet of Abuse in State Care Program claims circulated to Strengthening Safeguards Working Group members**

On 21 September 2020, a spreadsheet we understand was prepared by the Child Abuse Royal Commission Response Unit was circulated to members of the Strengthening Safeguards Working Group.<sup>2969</sup>

The spreadsheet collated information of claims made through the Abuse in State Care Program and identified that 127 claims had been made against Ashley Youth Detention Centre staff members (some of whom were named on multiple occasions).<sup>2970</sup> The email circulating the spreadsheet highlighted that two then current employees had been named as alleged abusers.<sup>2971</sup> This included Lester, who was named in four Abuse in State Care Program claims.<sup>2972</sup> However, the spreadsheet was incomplete because it was missing some Abuse in State Care Program allegations of which we are aware.

### **9.2.3 October 2020—The Department compiles a spreadsheet of all claims against Ashley Youth Detention Centre staff**

To address an action item of the 9 October 2020 Strengthening Safeguards Working Group meeting, the Department compiled a spreadsheet of all Ashley Youth Detention Centre staff who were mentioned in the Abuse in State Care Program, National Redress Scheme and/or civil claims.<sup>2973</sup> We were told that this new spreadsheet was prepared in response to concerns that the Child Abuse Royal Commission Response Unit spreadsheet (circulated on 21 September 2020) did not present a complete picture of all allegations against Ashley Youth Detention Centre staff (for example, those arising from civil claims) and that some information may have been omitted from the original spreadsheet.<sup>2974</sup> We understand that the online Government Directory Service was used to verify whether named alleged abusers were current State Service employees but that concerns were expressed that this did not constitute a ‘robust’ checking mechanism.<sup>2975</sup>

Despite attempting to reflect a fuller picture of allegations against current Ashley Youth Detention Centre staff, it appears that the review did not consider allegations raised through the Abuse in State Care Support Service, which included a claim against Lester.<sup>2976</sup>

We understand that this spreadsheet was later expanded and maintained.<sup>2977</sup> However, for reasons we discuss in Chapter 12, we are not confident that a comprehensive audit has been undertaken and we are unaware of any similar reviews relating to others named in claims who may still be working with children and young people (as carers or otherwise). In that chapter, we recommend that the Tasmanian Government conducts an audit of all relevant records it holds to identify all allegations of child sexual abuse.

### 9.3 August–September 2020—Processes for reporting to Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme are clarified and strengthened

We understand that in August or September 2020, concerns were raised internally that National Redress Scheme applications and civil litigation claims may not have been notified to Tasmania Police or the Registrar.<sup>2978</sup> Referring to these concerns, Ms Allen (who as we noted was relatively new to the Department) told us:

I considered that it was not Communities Tasmania’s role to decide if conduct amount[ed] to criminal misconduct, or an unacceptable risk to children (insofar as Registration to Work with Vulnerable People) and therefore we should be openly sharing information immediately once received with Tasmania Police and Registration to Work with Vulnerable People.<sup>2979</sup>

We agree with this observation. We observed that, in August and September 2020, the processes for reporting abuse allegations to Tasmania Police and the Registrar began to be considered and improved.

#### 9.3.1 Reporting to the Registrar

In 2018, the Office of the Solicitor-General prepared advice for the Department of Justice on the meaning of the word ‘finds’ in the Registration to Work with Vulnerable People Act, taking a view that there was only an obligation to report conduct that presented a risk of harm to a child if there had been a formal finding about that conduct. We discuss that advice in Section 12.2.

We were told that several senior officials in the former Department of Communities were unaware of that legal advice to the Department of Justice.<sup>2980</sup> However, it appears there was some confusion within the Department of Communities about what the actual reporting threshold to the Registrar was, noting the wording of the legislation at that

time. In August 2020, People and Culture contacted the Registrar to clarify reporting obligations, seeking confirmation of exactly when a reporting obligation arises.<sup>2981</sup> In that correspondence, People and Culture acknowledged that while the legislation appeared to require a ‘finding’ of reportable conduct to enliven the obligation, this could take some time to obtain and there was a desire to reflect best practice in reporting at the earliest opportunity.<sup>2982</sup>

A staff member from the Registration to Work with Vulnerable People Unit replied to People and Culture’s email stating:

The timely provision of information goes a long way [to protect vulnerable people from the risk of harm]. As such, we take and encourage a broad interpretation of the word ‘find’ so as to mean become aware of. We believe this is in keeping with the intent and purpose of the Act.<sup>2983</sup>

We were told that in around September 2020 (before changes to the legislation on 1 February 2021 clarifying the requirement to report described in Section 3.1.2), the Department changed its processes so information it received that constituted ‘reportable behaviour’ was immediately referred to the Registrar.<sup>2984</sup>

### 9.3.2 Reporting to Tasmania Police

We understand that prior to December 2020, the reporting of allegations of sexual abuse by government agencies generally occurred through informal relationships developed between Tasmania Police and government agencies within their local area.<sup>2985</sup> Notifications would be made in person, or via phone or email.<sup>2986</sup>

On 18 September 2020, the Strengthening Safeguards Working Group discussed the idea of establishing a central liaison contact in Tasmania Police for all redress and civil claims.<sup>2987</sup> We were told that shortly after the 18 September 2020 Strengthening Safeguards Working Group meeting, the Department changed its processes so matters were immediately referred to an appointed contact at Tasmania Police.<sup>2988</sup> Tasmania Police would then send the referrals to local police stations, with whom the Department (via People and Culture) would remain in contact.<sup>2989</sup> We understand this notification process took immediate effect.<sup>2990</sup>

Evidence we received from the Department and Tasmania Police was that Tasmania Police then changed its reporting processes for receiving child sexual abuse complaints from government agencies in December 2020, so all notifications of sexual abuse were made through the Assistant Commissioner of Operations’ office as a single point of contact through a specific inbox.<sup>2991</sup> Since February 2021, all agencies use a standard police template to report allegations of child sexual abuse committed by government employees.<sup>2992</sup>

In relation to the reporting of civil claims to Tasmania Police, we were told that the Office of the Solicitor-General advises the Department whether the matter has been referred to police.<sup>2993</sup> Where a referral is not made, the Department may nevertheless decide to refer the matter to police (having regard to the Office of the Solicitor-General's reasons for not referring already).<sup>2994</sup>

It appears that this process was not in place at the time the Department first started making referrals to Tasmania Police, and we note that the first referral from the Office of the Solicitor-General that Tasmania Police told us about was in November 2021.<sup>2995</sup> We consider that best practice requires that the Office of the Solicitor-General, as first receiver of the allegations in civil claims, refers all potentially criminal allegations derived from civil claims to Tasmania Police. If a referral has not been made, the Department should consider the Office of the Solicitor-General's reasons as to why, and the Department may decide to refer.

We note that while it appears the practice of reporting to the Registrar and Tasmania Police did improve around this time (including in relation to some allegations raised against Ira and Stan), we still saw some delays and inconsistent reporting practices until as recently as 2022 (discussed in Section 14).

## 9.4 October 2020—New departmental guidance developed for responding to National Redress Scheme claims

Minutes of a Strengthening Safeguards Working Group meeting on 18 September 2020 indicated there was no clear process in place for responding to information arising from National Redress Scheme claims, which began coming to the attention of the Department from 2019. The minutes record the need for a procedure 'to provide a clear process and detailed steps when current staff are identified' as a required action item.<sup>2996</sup>

As we have described earlier, the purpose of National Redress Scheme claims is primarily to offer acknowledgment and some form of compensation to victim-survivors of child sexual abuse in institutional settings, rather than to pursue alleged abusers. However, the National Redress Scheme does contemplate some claim information being reported, shared and acted on to the extent possible to protect the safety of children. Some of the information coming to the Department's attention through such claims related to serving Ashley Youth Detention Centre staff.

By early October 2020, a new 'process flowchart' and associated procedure was prepared to guide the Department's response to information it received in National Redress Scheme claims.<sup>2997</sup> It is unclear when exactly these documents came into operation (noting that the procedure we were provided with has a draft watermark and

unexplained highlighting, and has no effective date), but the minutes of the 9 October 2020 Strengthening Safeguards Working Group meeting suggest that it was around this time.<sup>2998</sup>

The flowchart provides for the following process:

- The Department of Justice emails the National Redress Scheme – Request for Information form (‘Request for Information form’) to the Department of Communities with a response due date, accompanied by information held by the Department of Justice relating to a National Redress Scheme claim.<sup>2999</sup> As we explained in Section 7, we saw that the Department of Justice did not always send the Department of Communities all the information it held about National Redress Scheme claims.
- A Department of Communities officer identifies relevant client records (including Abuse in State Care Program and Abuse in State Care Support Service records) and adds any necessary information to the Request for Information form.<sup>3000</sup>
- The Department of Communities officer emails the completed Request for Information form and a copy of the claim details provided by the Department of Justice to the Deputy Secretary Children and Youth Services (also known as the Deputy Secretary, Children, Youth and Families) and flags any alleged abusers who appear to be current government employees or departmental foster carers.<sup>3001</sup>
- The Deputy Secretary Children and Youth Services is to be alerted as soon as possible when an alleged abuser is identified as a current government employee or foster carer.<sup>3002</sup>
- The Deputy Secretary Children and Youth Services reviews the draft response and forwards this to legal services to ‘verify any civil matters’.<sup>3003</sup>
- The Deputy Secretary Children and Youth Services refers any concerns about current government employees to People and Culture for forwarding to the relevant Director (and any concerns about a current foster carer to the Director Children, Youth and Families for further review and investigation as appropriate).<sup>3004</sup>
- The Deputy Secretary Children and Youth Services approves the release of the completed Request for Information form to the Department of Justice.<sup>3005</sup>

We understand the requirement that the Deputy Secretary Children and Youth Services approves or ‘clears’ all Request for Information forms dates to at least late September 2020.<sup>3006</sup> Ms Clarke told us this requirement was embedded so she would, on a daily basis, be fully apprised of allegations being raised against departmental employees and because she ‘was starting to form the view that more [National Redress Scheme] forms alleging abuse of current [Ashley Youth Detention Centre] officials may occur’.<sup>3007</sup> She also said the requirement sought ‘to strengthen the linkage between the relevant



operational portfolios and the People and Culture Division’ because both divisions needed to work together when an allegation against a current staff member was received.<sup>3008</sup>

Although the flowchart requires that the Deputy Secretary Children and Youth Services is alerted as soon as possible when an alleged abuser is identified as a current government employee or foster carer, it otherwise does not include any specific timeframes for notifying People and Culture or the relevant Director about current employees.<sup>3009</sup> We were told that, in practice, the time between receiving a National Redress Scheme claim alleging abuse by a current staff member and the Department starting an initial assessment was ‘very prompt’.<sup>3010</sup>

The flowchart is limited to the Department’s response to a Request for Information form relating to claims under the National Redress Scheme and does not refer to any reporting obligations to Tasmania Police, the Registrar or Child Safety Services. We discuss the Department of Justice’s understanding of, and approach to, reporting obligations in Section 12.

## 9.5 November 2020—Media and parliamentary interest grows in alleged abuses at Ashley Youth Detention Centre

*The Nurse* podcast, created by freelance journalist Camille Bianchi, focused initially on abuses that occurred at Launceston General Hospital by paediatric nurse James Griffin and others (described in Case study 3 in Chapter 14).

On 3 November 2020, the fourth episode of *The Nurse* podcast aired. At the end of the episode, a preview was played for the forthcoming episode. The voiceover stated:

Next time on *The Nurse*, we go outside the hospital to another institution where Jim worked, in northern Tasmania. We go to the youth prison: you’re going to want to brace yourselves—it’s a horror show.<sup>3011</sup>

It then plays audio from a person who describes an allegation that we consider to be a reference to Lester:

There is one guard there who was witnessed engaged in the aftermath of raping a child. He was naked and the child was naked, and another guard saw it. For whatever reason a report was made that never went anywhere.<sup>3012</sup>

*The Nurse* podcast is mentioned in some of the briefing materials to Secretary Pervan, discussed in Section 9.6.

That same month, on 20 November 2020, journalist David Killick published an article in *The Mercury* newspaper referring to claims of sexual abuse and cover ups, commenting that Tasmania had an appalling record on handling Right to Information



requests. The article said that abuse claims in education, Launceston General Hospital and Ashley Youth Detention Centre ‘have been known in government circles but kept under wraps for months or years’ and asked: ‘How many child sex abuse scandals and cover-ups will it take for someone in this government to spot the pattern?’<sup>3013</sup> Three days later, on 23 November 2020, then Premier Peter Gutwein announced that a Commission of Inquiry into the Tasmanian Government’s responses to child sexual abuse in institutional settings would be established in early 2021.<sup>3014</sup>

On 25 November 2020 (a few weeks after Ira, Lester and Stan had been suspended, which we discuss in the next section), a question was raised in Parliament as to whether any of the Ashley Youth Detention Centre staff who had been publicly reported as having been ‘stood down’ were involved in strip searches in the period from 1 July 2019 to 30 June 2020.<sup>3015</sup>

On 26 November 2020, information was tabled in the Tasmanian Parliament that suggested that ‘of the three staff stood down or under investigation, none have [strip] searched young people’.<sup>3016</sup> The Department sought to correct this information by notifying Secretary Pervan in a Minute prepared on 9 December 2020 because Lester had in fact undertaken a strip search of a detainee in 2019.<sup>3017</sup>

## 9.6 November 2020—A change in approach to initiating disciplinary action

On Sunday 8 November 2020, a few days after the preview of *The Nurse* episode referencing what we consider to be the allegations against Lester, a meeting was held to discuss each of Ira, Lester and Stan.<sup>3018</sup> Secretary Pervan recalled that he had ‘various conversations’ with departmental staff about the matter in the week leading up to this meeting.<sup>3019</sup>

On the same day, Secretary Pervan considered and approved three Minutes (one each for Ira, Lester and Stan) concerning allegations raised against each and the possible disciplinary action to take place. At least two of those Minutes had been drafted on 6 or 7 November 2020.<sup>3020</sup> It appears it was at this point that the Department felt it necessary (and felt able) to recommend disciplinary action be taken against these three staff members.

The Minutes set out details of the relevant allegations against each of Ira, Lester and Stan. They did not include all allegations made about each employee that came to be known to our Commission of Inquiry. Only some (but not all) allegations known to the relevant departmental officials at the time the Minutes were prepared were included in the Minute. We describe some of the omissions from the Minute in Section 8.

The Minutes invited Secretary Pervan to consider four options in relation to the three staff members, being to:

- advise the staff member of the allegations against them and provide them with an opportunity to respond (essentially put the allegations to them for response)
- initiate an Employment Direction No. 5—Breach of Code of Conduct investigation
- reassign the staff member’s duties to prevent direct contact with detainees
- take no further action but maintain a record of the basis of that decision.<sup>3021</sup>

These same options were previously put to Secretary Pervan regarding Ira on 18 September 2020, which, as described above, resulted in a decision to put the allegations to Ira and provide him with an opportunity to respond (which was delayed to obtain his statement against Lester).<sup>3022</sup>

Across all briefings, Secretary Pervan was invited to consider a number of factors in making his decision, including the safety of detainees at Ashley Youth Detention Centre, the nature and severity of the conduct, the staff member’s potential exposure to young people, the level of information available and potential to progress an investigation (including whether the complainant wanted to take part), the public interest and the staff member’s wellbeing.<sup>3023</sup>

These considerations appear to extend beyond those articulated in the 2007 Solicitor-General’s advice, which primarily focused on the complainant’s participation. We acknowledge that the Minute relating to Ira advised that:

Previously it was considered there was insufficient information to provide reasonable grounds to believe that a breach of the Code may have occurred given [one] complainant [would not at that time] participate in an investigation.<sup>3024</sup>

The Minute, however, pointed to a ‘pattern of inappropriate behaviour’ that was now before the Department to justify overcoming the lack of a complainant’s participation.<sup>3025</sup> While the Minutes note the challenges of success without the participation of complainants, they nonetheless recommend disciplinary action—contrary to the practice we are told emerged from the 2007 Solicitor-General’s advice. No Minute expressly mentioned the 2007 Solicitor-General’s advice directly, or indirectly by describing its requirements.

Like the earlier 18 September 2020 Minute about Ira, Secretary Pervan was also given the following assurance across the different 8 November 2020 Minutes:

The allegations relate to alleged events over 20 years ago. It is considered that the environment at [the Centre] has changed significantly over the past 20 years, with additional controls now in place. There is greater staff to resident ratios, less of an opportunity for Youth Justice Workers and residents to be in 1:1 situation, more cameras and monitoring, and a greater opportunity for residents to raise complaints. Given these additional controls it is considered a lower risk that abuse such as that outlined in the allegations against [the relevant employee] could occur in the environment at [the Centre] today. However, whilst it is considered that risk is minimal it may not be possible to eliminate risk, especially if [an employee] is in direct contact with residents.<sup>3026</sup>

Only one Minute made any reference to media attention and scrutiny over child sexual abuse matters. It noted the significant media attention that was occurring about child sexual abuse, particularly involving James Griffin.<sup>3027</sup> The Minute also referenced the upcoming release of *The Nurse* podcast episode on Ashley Youth Detention Centre.<sup>3028</sup>

Ultimately, Secretary Pervan decided to suspend all three Ashley Youth Detention Centre staff and initiate Employment Direction No. 5 investigations because he had formed a reasonable belief that each may have breached the State Service Code of Conduct.

In an email approving all three Minutes, Secretary Pervan suggested that steps had not been taken over the allegations until that point because the Department did not want to interfere with police processes.<sup>3029</sup> The email noted that as police had advised they did not intend to pursue criminal investigations, ‘the way is therefore clear for us to pursue our process’.<sup>3030</sup> The email did not acknowledge that police had notified the Department in February 2020 that they would not be pursuing Baxter’s allegations against Ira, clearing the way for much earlier action.

We are pleased to see more decisive action occurred on 8 November 2020. However, we consider it took too long to give serious consideration of the public interest and a possible pattern of behaviour revealed through multiple complaints.

### **Finding—The Department failed to adequately consider the safety of detainees and place appropriate weight on public interest considerations in relation to Ira, Lester and Stan until 8 November 2020**

Despite the Department becoming increasingly aware of the extent of allegations being made against current staff by August and September 2020, we were disappointed that it took until 8 November 2020 for disciplinary action to be commenced in relation to the allegations made against certain Ashley Youth Detention Centre staff.

For example:

- The Department had the same information about Ira in September 2019 that it had on 8 November 2020. It had provided the Secretary with three previous briefings from December 2019, none of which recommended that Ira be suspended or an Employment Direction No. 5 investigation be commenced.

- The Department received Alysha’s report about Lester on 9 January 2020, which was the only allegation initially included in the Employment Direction No. 5 investigation into Lester’s conduct on 8 November 2020. Also, the Department had reidentified that there were four Abuse in State Care Program claims against Lester in September 2020, yet only recommended disciplinary action to Secretary Pervan on 8 November 2020 (referring to only three of these claims).
- The Department had received Ben’s allegations of rape by Stan by mid-2020. This was the only allegation initially included in the Employment Direction No. 5 investigation against Stan on 8 November 2020, noting that the Minute also referred to other allegations it had received in September 2020.

While we accept responding to allegations of this nature is complex, the Department owes a duty of care to detainees that must be at the forefront of decision making. We note that the Department became aware of the relevant allegations a number of months—and in one instance, more than a year—before making the decision to suspend those staff members.

We acknowledge there was growing concern within the Department from September 2020 onwards but were surprised by the markedly different change in approach on 8 November 2020, which showed welcome emphasis on the safety of detainees and the public interest in having staff the subject of allegations removed from the workplace and investigated.

We are unclear why this outcome could not have been achieved earlier, given, at this point, there had been no apparent change to the legal advice that we were told precluded any disciplinary action without the participation of, or a sworn statement from a complainant, or to the practice that appears to have developed from that advice.

While increasing awareness of the number and nature of complaints against past detainees from September onwards can partly be attributed to this change, we also consider it likely that the growing appreciation of risks to the Department, arising from the looming class action and increased media scrutiny, was a significant contributor to the relatively sudden recommendation to take decisive action.

## 9.7 December 2020—Secretary Pervan receives the Department’s Review of Claims of Abuse of Children in State Care

In or around December 2020, the Department prepared a review of the reporting processes under each of the four Abuse in State Care Program rounds, which considered the notifications process and the scope and aims of the program.<sup>3031</sup> We discuss this review, and what it revealed about the purpose of the program in Section 4.2.

On 14 December 2020, the Department sent Secretary Pervan this review. The associated cover email included an extract from the review, which stated that the program was about compensation and acknowledgment and was not established to determine blame or fault or to make specific findings against alleged abusers. Rather, the Abuse in State Care Program was intended to be part of a supportive, healing reconciliation process.<sup>3032</sup>

Secretary Pervan responded on 14 December 2020 to the email as follows:

I acknowledge the intent of the Review ... in terms of compensation and healing and of the advice you have compiled for Mandy [Clarke]. In the context of claims and harm done that is entirely understandable.

I do think however, that if we consider these matters in the current context of our duty of care to children in our care and include in that consideration the statutory provisions relating to reporting and responding to abuse and the associated penalties where it is proven, then a different perspective on the information and our compulsion to act emerges.<sup>3033</sup>

This statement would appear to reflect the position taken on 8 November 2020, when Employment Direction No. 5 investigations were commenced against Ira, Stan and Lester.

## 9.8 December 2020—The Department seeks and receives new legal advice from the Office of the Solicitor-General on using information alleging abuses by Centre staff

We saw some evidence that the 2007 Solicitor-General’s advice, or any practice associated with it, was not viewed as an immovable barrier to disciplinary action. But this was clear by November 2020, when Ira, Lester and Stan were suspended. In each of those three matters, the Department did not have the active participation of, or a sworn statement from, the relevant complainant at the time of the suspension.

Despite our efforts to enquire into the rationale for taking that disciplinary action at that specific time, we remain unclear about any change in policy or legal position that produced this different approach, until new legal advice was received on 15 December 2020.

We were told that the ‘number and detail of the allegations’ relating to Ira, Lester and Stan ‘distinguished them from earlier matters’ such that a disciplinary response was appropriate in November 2020 despite the continued application of the 2007 Solicitor-General’s advice.<sup>3034</sup> We found this difficult to reconcile with the lengthy period over which these allegations were known to the Department (noting in particular the allegations against Ira, which had been briefed to the Secretary as early as December 2019).

In July 2023, Secretary Pervan told us that since his previous evidence to us he had recalled being informed by People and Culture earlier than 15 December 2020 that the Office of the Solicitor-General had confirmed the 2007 Solicitor-General’s advice would be superseded.<sup>3035</sup> Secretary Pervan could not recall whether this occurred before or after the decision to approve Employment Direction No. 5 investigations into the allegations against Ira, Lester and Stan on 8 November 2020.<sup>3036</sup> We did not receive evidence from other departmental witnesses suggesting this advice had been given at this time, although we did not have an opportunity to test this recollection with relevant people before publishing our report.

We received evidence that the 2007 Solicitor-General’s advice was reinforced in a meeting in November or December 2020 between representatives of the Office of the Solicitor-General and the Department.<sup>3037</sup> As we note above, we consider that heightened media attention and scrutiny likely played some role in the Department’s changes in processes and practice during this period.

We outline here the evidence that we received about the lead-up to providing the 15 December 2020 legal advice, noting it suggests that:

- there continued to be real or perceived legal barriers to taking disciplinary action, even after the initiation of Employment Direction No. 5 investigations on 8 November 2020
- concerns about taking disciplinary action based on information from redress schemes was a matter exercising many Secretaries
- the extent to which the 2007 Solicitor-General’s advice affected the Department’s practice in managing allegations against staff (particularly by 2020) remains unclear.

At some point, the Department must have become concerned about potential barriers to using information from redress schemes in disciplinary processes.

On 23 November 2020, departmental staff met with the then Assistant Solicitor-General (and current Solicitor-General) Sarah Kay SC to discuss the Department using information about historical allegations of abuse.<sup>3038</sup> We were told that Ms Kay confirmed at the meeting that the Department could not progress investigations where there was no complainant.<sup>3039</sup> Some departmental officials expressed feeling upset with the advice.<sup>3040</sup> They felt ‘very frustrated with a seeming inability to do anything when there were serious allegations against current employees’.<sup>3041</sup>

The Office of the Solicitor-General told us, and provided documentary evidence to support, that no legal advice was provided at that 23 November 2020 meeting, including advice that investigations could not be progressed.<sup>3042</sup> The Office of the Solicitor-General considers that the contents of that discussion may have been misinterpreted by the staff of the Department.<sup>3043</sup>

On 24 November 2020, Secretary Pervan emailed the then Solicitor-General stating that he had been briefed by staff about the meeting with Ms Kay on the previous day. The email stated:

I understand that the material provided to us from civil claims and redress statements cannot be used for disciplinary purposes but remains live and usable by the Crown for the purpose of settling claims. As you know, the victims in 2 of the matters have made it abundantly clear that they do not wish to participate in any investigation by the Police or the Crown generally. Given that one of the employees in particular is accused of a significant number of potentially criminal acts this places us in a poor position.<sup>3044</sup>

Secretary Pervan also requested advice on the Department's mandatory reporting obligations, in addition to the advice that was being drafted about using historical information.

We asked Secretary Pervan about this email and what the basis was for his statement that material provided from civil claims and redress statements cannot be used for disciplinary purposes.<sup>3045</sup> He responded:

The verbal preliminary advice from Sarah Kay was that in the absence of a sworn statement from the victim-survivor, the claims could not be used in ED5 investigations. This maintained the position that we had understood we were bound by, set out in the 2007 written advice.<sup>3046</sup>

On 6 December 2020, the Department requested new advice from the Solicitor-General, asking:

- whether investigations could be initiated without the complainant's consent
- whether the Department could provide information received through the state and national redress schemes and civil claims to external investigators
- whether the Department could use that information as part of a misconduct investigation in circumstances where the complainant had not made a formal complaint to the police or a statement to the Department.

On the one hand, this request for legal advice suggests the Department was actively seeking legal advice to enable it to share and act on information about child sexual abuse by staff gleaned from redress and civil claims. On the other hand, it illustrates there continued to be real or perceived barriers to taking this action, despite the Department initiating disciplinary processes a month before.



Ms Baker explained her concerns this way, in the context of managing the disciplinary process against Lester:

Noting that [Lester] was out of the workplace and the risk to children mitigated from 8 November 2020, there was a delay in progressing the Abuse in State Care matters to [Lester]. This was initially attributable to seeking advice from the Office of the Solicitor General to ascertain whether the information (including the complainant[’s] name) from the Abuse in State Care Scheme could be put to [Lester]. This was the first case where we were relying on information from the Abuse in State Care Scheme to put matters to an employee. I recall the discussion at the time on how this was unprecedented and legal advice needed to be sought. This advice was sought at a meeting between Department staff and the Office of the Solicitor General and was held on 23 November 2020, written advice was sought on the 8 December and the written advice was received from the [Office of the Solicitor-General] on the 15 December 2020.<sup>3047</sup>

On or around 7 December 2020, there was a multi-agency meeting at which there was a discussion about:

... the use and retention of information concerning claims of child sexual abuse made in the course of seeking financial compensation under the National Redress Scheme and the need to take action in respect of alleged perpetrators who were still in contact with children in their roles.<sup>3048</sup>

We understand the meeting attendees included Secretary Pervan, Ms Clarke, Assistant Commissioner Higgins, the then Director of the Child Abuse Royal Commission Response Unit, Secretary Webster, Secretary of the Department of Health, Kathrine Morgan-Wicks PSM, and the then Deputy Secretary of the Department of Education, Rob Williams.<sup>3049</sup> Secretary Pervan told us:

Although I do not recall specific statements, my general recollection is that attendees were forthright about their dissatisfaction with [the 2007 legal] advice and its practical repercussions. I recall that this meeting was the catalyst to request that the Solicitor General provide updated advice on these matters, including with respect to how the Department could engage with employment directions using information arising from the [National Redress Scheme] claims that it had received from the Department of Justice.<sup>3050</sup>

As mentioned above, Secretary Webster told us that she only ‘recently’ became aware of the Solicitor-General’s 2007 legal advice and that she understands:

... this advice may have resulted in these [Abuse in State Care Program] allegations not being pursued, however, this understanding is based on the evidence that has come to light during the Commission’s hearings.<sup>3051</sup>

The decision to request the 15 December 2020 legal advice was made on 23 November 2020 and there was no reference to the Solicitor-General’s 2007 legal advice in that request.<sup>3052</sup>

On 8 December 2020, there was a meeting between Secretary Jenny Gale, Secretary Webster, Secretary Pervan, Secretary Morgan-Wicks, Secretary Timothy Bullard and former Commissioner of Police, Darren Hine AO APM.<sup>3053</sup> The purpose of the meeting was to determine responsibility for a paper to Cabinet about internal processes for identifying whether and where employees who may have had historical allegations against them are still employed by the State and the need to ensure there was information sharing across agencies to identify whether an employee had moved from one agency to another.<sup>3054</sup> We understand this meeting, or discussions that followed it, included discussion about the reliance on a statement from redress claims for the purpose of disciplinary processes and the complexity this entailed.<sup>3055</sup>

On 15 December 2020, the Office of the Solicitor-General advised the Department that:

- The Department could commence a misconduct investigation in the absence of a complaint to Tasmania Police or a statement to the Department.<sup>3056</sup>
- The Department did not need to notify a complainant it was acting on the information provided unless the Department's actions might adversely affect the complainant.<sup>3057</sup>
- The use or disclosure of information derived from National Redress Scheme claims is permitted in certain circumstances by the Scheme's legislation. This includes disclosure or use in relation to the safety or wellbeing of children or related disciplinary or employment processes (including an Employment Direction No. 5 investigation).<sup>3058</sup>
- In certain circumstances, exceptions in the Personal Information Protection Act may enable the use of information for the purposes of Employment Direction No. 5 investigations without the complainant's consent.<sup>3059</sup> Those exceptions have been in place since 2004.<sup>3060</sup>

This new legal advice did not reference the 2007 Solicitor-General's advice and did not explain the reason for the change in view. We understand that the legal advice of 15 December 2020 is still current.

We were told that these measures worked to improve reporting to other agencies, reduce delays and allow for more effective disciplinary responses.<sup>3061</sup> We welcome information that expressed a shift towards prioritising detainee safety, including by working to remove staff from site where required.<sup>3062</sup> Departmental officials placed particular emphasis on the difference in approach since receiving the Solicitor-General's legal advice on 15 December 2020.<sup>3063</sup>

We also heard of efforts to overcome reliance on police investigations as a reason to wait to start disciplinary action. We were told that since 2020, 'generally speaking' there were not the same concerns about delaying Employment Direction No. 5

investigations pending police processes but in some cases, a person will be suspended and the Department will wait for police to confirm that the Employment Direction No. 5 investigation can begin.<sup>3064</sup>

Many departmental officials told us that the Department's responses to the allegations against Lester, Ira and Stan would be different if the allegations were made today.<sup>3065</sup>

## 9.9 Reflections on the Department's responses to Ira, Lester and Stan

We have outlined responses to allegations against Ira, Lester and Stan in this case study because they illustrate some significant failings in the responses of the Department and other agencies. They also highlight the complexities of responding to such matters. We recognise that the task of investigating allegations of child sexual abuse by staff is a difficult exercise that requires careful consideration, risk assessment and clear processes and supports for all parties. It requires consideration of risk to children and young people, as well as care towards complainants and fairness towards the staff subject to the allegations. It also requires close cooperation and collaboration across multiple agencies—particularly Tasmania Police and the Registrar. This requires broader systems to be designed and applied in a way that promotes the safety and best interests of children and young people.

Overall, our examination of these case examples revealed that neither occurred; systems were poorly designed or not developed at all and this greatly affected the availability and sharing of information that could enable action to be taken to protect children from potential risks over decades.

The culture we observed within the Department was indicative of an attitude we saw across the State Service—one that focused on adherence to bureaucratic processes and procedures and was conservative about the prospects of substantiating allegations of misconduct. We do not consider such reservations to be entirely unfounded, based on what we learned about the State Service disciplinary framework.

We are also conscious that the Department was beginning to face an unprecedented crisis, with numerous allegations against a substantial number of staff. We have sympathy for the challenge the Department was, and is, facing.

Through the period 2019 to 2020, we would have liked to have seen allegations made against staff treated with urgency, with proactive effort to overcome barriers that produced outcomes that directly placed detainees at risk. We would have also liked to have seen the setting of expectations within the Department that allegations would be addressed and referred without delay. We consider that the circumstances the Department described (of not being able to take action on critical information that suggested staff may be a risk to detainees) should have been intolerable for the Department, yet it was allowed to stand

for years and years. We were not advised of any proposals for legislative change made by the Department to overcome the problems. We were pleased to see more decisive action on 8 November 2020, where there was finally serious consideration of the public interest and a possible pattern of behaviour revealed through multiple complaints. We also welcome the legal advice received in December 2020, which gives the Department greater power to act on abuse allegations it receives about staff.

## 10 Responses by Tasmania Police

Tasmania Police plays a critical role in keeping children and young people safe from sexual abuse and misconduct and for holding abusers accountable. In this context, we identified several areas regarding Tasmania Police's response to allegations of child sexual abuse by Ashley Youth Detention Centre staff that could be improved, including information-sharing processes, police attitudes, recognising allegations of abuse, overcoming barriers to investigations, and coordinating its response with other agencies.

### 10.1 Quality and clarity of information held about abuse allegations and deficiencies in reporting processes

We are concerned about the quality and clarity of information we received from Tasmania Police regarding our case examples. In response to our request for information about the reports it received and made, and the actions it took in response to allegations relating to certain Centre staff members, we received multiple iterations of a table of allegations that contained different pieces of information.<sup>3066</sup> While we appreciated efforts to correct information through the course of our Inquiry, we are concerned about the reliability of police mechanisms to track and record this important information.

Also, information provided by Tasmania Police often did not align to the reporting dates or allegations provided by the Department or did not exist at all. For example, while we are aware the Department sent a letter to Tasmania Police on 18 February 2020 about Baxter's allegations against Ira, the police did not provide us with any information about this notification.<sup>3067</sup> It was difficult for us to tell why this was the case.

We also note there have been some significant delays by Tasmania Police in making notifications to the Registrar, as well as instances where it appears no notifications were made—suggesting the automatic notification process adopted was not working as intended. Examples from the case examples we considered include:

- On 9 November 2020, the Department reported allegations raised against Lester through the Abuse in State Care Program to Tasmania Police.<sup>3068</sup> However, the police did not enter these notifications into their intelligence system until 18 August 2022.<sup>3069</sup> As a result, Tasmania Police did not notify the Registrar of these allegations until that time.<sup>3070</sup> We were told this was an oversight by Tasmania

Police and the allegations should have been entered into its intelligence system and reported to the Registrar in November 2020.<sup>3071</sup>

- Tasmania Police told us that it notified the Registrar of Parker’s allegations against Ira on 11 August 2022.<sup>3072</sup> This was more than a year after Tasmania Police was notified of the allegations by a third party (and almost two years after the Department says it reported the allegation to the police).<sup>3073</sup>
- Ben’s allegations against Stan were reported by the Office of the Solicitor-General to Tasmania Police in November 2021, but were not listed as ‘presents a risk to vulnerable people’ on Atlas until 19 August 2022.<sup>3074</sup>
- Despite receiving a submission to the National Royal Commission containing allegations against Ashley Youth Detention Centre staff in May 2017, Tasmania Police did not report this to the Registrar through its automated referral process.<sup>3075</sup> Assistant Commissioner Higgins agreed that this is an example of how the process is subject to ‘human error’.<sup>3076</sup>

Prompt notifications to the Registrar are particularly important where conduct may not satisfy a criminal threshold but nonetheless may point to a person being a risk to children.

We are also not confident that the information that has been provided to us by police is complete. We have received evidence that the ability to search for an individual is based on the accuracy of information provided and the ability of the police to link that person to a report.<sup>3077</sup> In the past, the manual entry of names meant that people were not identified or linked to a report due to incorrect spelling.<sup>3078</sup> We were told that while this still occurs and the system is ‘not always perfect’, the process has been improved by requiring the person inputting the data to find the offender’s name and date of birth on the system.<sup>3079</sup>

We are concerned about problems with the accuracy and clarity of information held by police because any single piece of information can be vital to a criminal investigation. It is important that police databases enable all relevant information about an individual to be linked, accessible and accurate to give police a complete picture of its holdings. What may seem relatively insignificant in isolation can become crucial as further information emerges and is vital to establishing and understanding patterns of behaviour.

In relation to deficiencies in information provided to our Inquiry by Tasmania Police, we were told that this was due to unintentional oversights in the compilation of the information.<sup>3080</sup> Assistant Commissioner Higgins told us:

I do accept that our notifications to external agencies relating to Ashley Youth Detention Centre staff have been deficient at times. This has been a result of incomplete, minimal data, or a failure on our behalf to validate information with the Department of Communities on entities identified within reports. To expand on this, incomplete and minimal data relates primarily to Redress and civil claims, where

information at times can be limited for example to a surname only ... Without prior knowledge of the individual, these individuals may not be correctly linked with the occurrence within ATLAS which results in no automatic notification being made to either Communities or Working with Vulnerable People.<sup>3081</sup>

He noted that Tasmania Police had begun a review of matters relating to Ashley Youth Detention Centre to ensure the correct people are linked and accurate information can be provided to other agencies.<sup>3082</sup>

We received evidence that December 2020 was a ‘pivotal time’ and during this period changes in protocols, guidelines and training led to 94 per cent of sworn police staff members receiving online training, including about requirements for making intelligence submissions and ticking the appropriate boxes for referrals.<sup>3083</sup> Assistant Commissioner Higgins had observed ‘a measurable change’ and ‘more correct reporting’ as a result of this training.<sup>3084</sup> He also described systemic safety nets, such as further supervision and audits.<sup>3085</sup> He acknowledged that while there will be human errors on occasion, he generally has confidence in the system, which is now far more robust.<sup>3086</sup>

## 10.2 Police attitudes towards detainees

We observed concerning attitudes among some police members regarding detainees. We saw detainees being openly described as ‘the worst of the worst’.<sup>3087</sup> Some police members also suggested to us that detainees only make complaints to receive compensation and that those processes make it ‘too easy’ for complaints to be made without being substantiated.<sup>3088</sup>

People with criminal histories can be reluctant to report abuse because of the stigma associated with reporting but also due to distrust of police, an issue we discuss in Chapter 16. Some former detainees told us that staff who inflicted abuse on them told them that no one would believe them because they were just criminals, or that they felt they would not be believed if they made a report due to their criminal history.<sup>3089</sup>

One senior departmental official told us about a conversation they had with a police officer they called to discuss an allegation against an Ashley Youth Detention Centre staff member:

I distinctly recall the officer I was talking to laughing when I relayed the claims against [the staff member] and the disbelief of this officer that we were taking the steps to suspend the employee as this complainant was apparently from a well-known criminal family, had a long criminal past, and that [their] word should not be trusted, especially when there was money involved.<sup>3090</sup>

At the hearings, Counsel Assisting asked Assistant Commissioner Higgins whether he had any concerns that members of the police may be less open to believing allegations that are made by detainees as distinct from other members of the community.<sup>3091</sup> He told us:

It’s possible. Would it be common practice? No. I think, watching a witness this



morning, I think you'd only have to watch a victim in that case to realise how raw it is and how compelling their experience is to be able to put your personal view on the veracity of something. So, it's difficult to say. The only thing I'd say to qualify that is that, the sad reality of the detainees at Ashley over lengthy periods is that they have had very long histories with police, so there perhaps is on occasion scepticism.<sup>3092</sup>

Assistant Commissioner Higgins conceded that Tasmania Police needed 'to work on [its] unconscious bias' against detainees.<sup>3093</sup> He also acknowledged the need to educate police officers about abusers using the fact that the children are 'criminals' as a tool to stop them from disclosing because of the perception that no one will believe them.<sup>3094</sup>

We discuss this issue—including the relevant recommendations of the National Royal Commission that directed police to consider the credibility of complaints rather than the credibility of the complainant alone—in Chapter 16.

### 10.3 Failures to recognise allegations as potential child sexual abuse

As with the Department, we observed a failure by police to recognise some of the alleged conduct as potentially criminal in nature. Our consultation with Launceston Police indicated that police officers had received reports relating to Ashley Youth Detention Centre staff rubbing cream on detainees' genitals, watching detainees in the shower and watching them masturbate.<sup>3095</sup> Some members of Launceston Police told us this occurred in the context of staff doing their job and that it does not constitute child sexual abuse.<sup>3096</sup> This is consistent with the view police have taken in response to similar allegations—for example, allegations of unlawful strip searches.<sup>3097</sup>

We are troubled by this assessment because we consider that, accounting for the relevant context and particulars, including departmental policies that may dictate how strip searches or other procedures in detention should be undertaken, such behaviours may indeed constitute child sexual abuse and should be treated as such. There is now a wider range of offences available to police regarding child sexual abuse following Tasmania's implementation of the National Royal Commission recommendations. This includes broader offences relating to perpetrators but also offences relating to failures by institutions (such as failures to report or act on information). Tasmania Police should always consider the full suite of offences and powers it has when considering allegations, and not make assumptions about the nature of alleged conduct (for example, that it was lawfully undertaken in the course of duties) without further investigation.



## 10.4 Overcoming barriers to investigations

We acknowledge challenges arise for police when complainants do not want to provide statements or otherwise participate in criminal justice processes—particularly where the alleged conduct may have occurred some time ago and other evidence (such as records or witnesses) may be difficult to secure. Complainant reluctance would be more pronounced among current and former detainees, and police receive information through National Redress Scheme claims and sometimes do not have the name and details of a complainant, often having to go through third parties (such as lawyers or victim support groups) to make contact. Often, too, the complainant has indicated they do not wish to be contacted by police, which should be respected.

We consider that, rather than passively accepting these barriers (particularly in the context of multiple, serious allegations against people working with children) police should adopt proactive policing strategies, including building trust with current and former detainees. Public calls for information or dedicated reporting channels may also demonstrate police commitment to receiving and responding to such complaints. We also note that complainants can believe they are the only victim and, if later advised of other complaints, may change their minds and be more willing to proceed.

## 10.5 Reducing delay and ensuring institutions do not unduly defer to police

In relation to our case examples of Ira, Lester and Stan, we identified a tendency of the Department to defer to police as a justification for inaction in responding to certain allegations. We recognise that it is appropriate for the Department to consult with Tasmania Police about its intentions to ensure it does not in any way interfere with a police investigation, although note that this should not compromise child safety. As a general observation, once Tasmania Police was notified of allegations, it was often relatively prompt in confirming its intentions (for example, to not investigate an allegation further) to clear the way for the Department to pursue disciplinary action. We consider this important.

However, we also consider it important that Tasmania Police is aware of the need to manage the active risks posed by those who are the subject of allegations and its role in reminding institutions of their responsibilities to keep children safe while investigations occur. Risk management may need to be designed on a case-by-case basis and in a collaborative way between Tasmania Police and the relevant institution. We consider the introduction of Tasmania's Reportable Conduct Scheme (discussed in Chapter 18) so that responses to allegations of abuse within organisations are overseen by an Independent Regulator, will ensure this occurs.

We note that, following acknowledged failings in police responses to information received around now deceased abuser James Griffin (discussed in Chapter 14), Tasmania Police has initiated a range of reforms to improve and clarify its responses to reports of child sexual abuse. These are described in Chapter 16. It is important that these reforms are applied equally to consideration of safety for children in the community and those in the care of the State, including in youth detention.

## **Finding—Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre**

While we recognise several recent improvements, Tasmania Police must continue to improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre. This includes responding to allegations made against former Centre staff. The fact a child or young person has previously engaged in criminal behaviour does not, and should not, deny them the right to live free from abuse and harm and to have any allegations they make taken seriously and investigated thoroughly.

In Chapter 16, we make several suggestions and observations about how Tasmania Police can improve its responses to child sexual abuse, but note in the context of this case study that Tasmania Police should improve its responses to this cohort in the following ways:

- Adopt proactive strategies to build trust with current and former detainees.
- Implement and further embed the recommendations of the National Royal Commission as they relate to complainants who may have criminal histories—by avoiding judgments of character or assessments of credibility based solely on views about the character of the complainant rather than the nature of the complaint.
- Improve its information-sharing and referral practices to ensure other agencies (including Child Safety Services and the Registrar) receive information, where appropriate, to enable those agencies to take steps to protect the safety of detainees.
- Improve record keeping to ensure all allegations and information received is accurate, accessible and appropriately linked to relevant individuals. It is important that any piece of information relating to child sexual abuse is treated as potentially important so that police can identify patterns of behaviour over time.

- Investigate all allegations thoroughly using all available tools, powers and potential offences available. While we accept police will not always be able to pursue an investigation without the participation of a complainant, we consider there may be instances (for example, where there are several past complaints) where police may be able to form a basis for actions, such as obtaining a search warrant to try to elicit further information. Police may also be able to interview other potential witnesses to gather information (for example, other staff) or re-engage with past complainants to see whether they may wish to proceed with a formal complaint at a later time (particularly if other complaints have been made since).
- Specifically regarding allegations made by current or former detainees in youth detention, police need readily accessible guidance on Tasmanian law on personal searches, isolation and use of force so they can quickly identify when the alleged conduct falls outside of the parameters of acceptable professional conduct and may indicate a crime has occurred.

## 11 Responses by the Registrar of the Registration to Work with Vulnerable People Scheme

The Registrar plays one of the most important roles in the context of responding to allegations against staff in institutions.

The Registrar has a primary focus on the safety of vulnerable people, including children, in its decision making and is often not bound by the limitations of other agencies (such as the Department, which must act within a rigid industrial framework, or Tasmania Police, which requires allegations to suggest there has been a defined criminal offence and to meet higher standards of proof). A loss of registration can also protect children in a wider range of settings beyond the institution where the allegations arise. For example, state servants who are the subject of allegations may also rely on registration to volunteer with children or to be foster carers. However, we recognise that the loss of registration—particularly for those in child-facing roles—has serious impacts. It can end their career and preclude them from undertaking a wide range of activities in the community. Therefore, it is proper and appropriate that the Registrar acts carefully in making adverse decisions and has the best possible information to do so.

The Registrar told us that, as of 15 August 2022, there were 16 current or former Ashley Youth Detention Centre staff who continued to be subject to an additional risk assessment.<sup>3098</sup> We received evidence that, at that date, no negative Employment

Direction No. 5—Breach of Code of Conduct outcomes had been provided to the Registrar relating to Ashley Youth Detention Centre staff.<sup>3099</sup> Describing the impact of these delays on the Registrar’s functions, the Registrar told us:

... we don’t have outcomes from investigations that started in November 2020, nor do we have any real appreciable information that’s come from those investigations that would enable us to make decisions to remove people from settings where they may cause harm.<sup>3100</sup>

The Registrar has significant powers to suspend registration and has issued some suspension notices on the basis of the volume or similarity of allegations against a registered person before police or employee conduct investigations begin, charges are laid or findings made.<sup>3101</sup> However, given the challenges associated with allegations that lack specificity, are isolated in nature and in respect of which there are not timely investigatory outcomes, there are some cases where the Registrar considers it is not appropriate to suspend registration while another risk assessment is undertaken.<sup>3102</sup> We discuss this in Chapter 18.

We received evidence that the Registrar experienced several challenges and frustrations in executing his functions in relation to information he received regarding allegations about staff in Ashley Youth Detention Centre.

In December 2020, the Registrar was provided with a spreadsheet with more than 300 allegations of child sexual abuse and physical abuse relating to current and former Centre staff. We were told that the Registrar assumed this was a starting point for receiving further, more comprehensive information. However, it became clear in February 2021 that there was:

... an apparent reluctance within parts of [the Department] to share records from the redress scheme under reportable behaviour obligations in the [Registration to Work with Vulnerable People] Act.<sup>3103</sup>

We understand that, in mid-2021, many Ashley Youth Detention Centre staff were due to renew their registration and that the Registrar felt that he could not decide that the members of staff posed an unacceptable risk (thereby removing their registration) without more information.<sup>3104</sup>

In light of the difficulties the Registrar faced, in March and April 2021, the Registration to Work with Vulnerable People Unit began a full review of the spreadsheet provided to it by the Department in December 2020 to log reportable behaviour and start additional risk assessments.<sup>3105</sup> However, this resulted in only eight registered people being identified.<sup>3106</sup> In an attempt to verify the identities of the remaining records included in the spreadsheet, requests for information were sent to the Department. This included clarifying names or dates of birth of persons named in the spreadsheet.<sup>3107</sup>

We understand that in response to one of these requests from the Registrar, the Department confirmed it was seeking advice on releasing information about redress claims and confirmed on 16 March 2021 that it could provide all relevant information about redress claims to the Registrar.<sup>3108</sup> We understand this approach was adopted after the Department sought legal advice about the Registrar’s powers to request information.

The Department received advice from the Office of the Solicitor-General dated 12 March 2021, that indicated the Registrar could request such information and there was no barrier to sharing this information with the Registrar under the Personal Information Protection Act or the National Redress Scheme legislation.<sup>3109</sup> We note the 15 December 2020 legal advice (discussed in Section 9.8) had previously indicated that the legislation permitted the use and disclosure of such information in certain circumstances.<sup>3110</sup>

We were told that, over the period from May 2021 to August 2022, the Department provided information about reportable behaviour relating to a further 14 current and former staff concerning conduct that occurred at the Centre.<sup>3111</sup> However, we received evidence that the Department did not respond to requests for information in a timely way. The Registrar told us that his office had made more than 80 requests for information and that it took the Department up to a year to respond to some of these requests.<sup>3112</sup> Sometimes the records ultimately provided by the Department did not contain much more information than the Registrar already had.<sup>3113</sup> We have noted the problems the Department had with record keeping and accessing records throughout this case study.

The Registrar reported difficulties his office faced around limited particulars on allegations raised through the National Redress Scheme—sometimes due to limited information within the claim itself but also because the Department had not always provided all relevant information.<sup>3114</sup> We note that until at least October 2020, the Department had less information about these claims than the Department of Justice. We return to this issue in Section 12.

The Registrar told us that, even though requests were made to the Secretary in November 2020 for continuous disclosure from Employment Direction No. 5 investigations, the Department had not provided records about such investigations, which form a vital source of information for the Registrar.<sup>3115</sup>

The Registrar highlighted delays in appointing investigators to undertake Employment Direction No. 5 investigations, giving the example that one of the staff members who was suspended in November 2020 was yet to have allegations put to him as of July 2021.<sup>3116</sup> The Department told us that typically the Minute recommending the commencement of an Employment Direction No. 5 investigation includes the relevant appointment documentation for the investigator, but acknowledged there were sometimes delays associated with securing suitably skilled and trained investigators and gathering all the necessary records.<sup>3117</sup> Also, the Registrar noted that there were no investigations into allegations where the alleged abuser was a former staff member.<sup>3118</sup>

The Registrar also reported that often responsibility for managing such matters in the Department would shift multiple times between People and Culture, Legal Services and the Records and Program areas ‘with a sense that no area particularly saw themselves as accountable’.<sup>3119</sup> Secretary Pervan acknowledged that there were some restructures within the Department, but that at the time of our hearings there was greater resourcing of the records and legal areas to support such processes.<sup>3120</sup>

Describing his decision to send the Department 80 requests for information in 2021, the Registrar accepted that even though his role is not investigative, his unit was forced to adopt a quasi-investigative role to progress matters:

... these were allegations of particularly grave conduct, albeit with no real particulars, so it was very hard: you’re sort of sitting with something that you need to make a decision on, potentially a suspension decision on, but you don’t really have information about it, so trying to understand more about the people who were alleged to have taken it was a vital kind of step.<sup>3121</sup>

The Registrar told us that, in July 2021, his frustrations with the lack of information being provided led him to consider whether enforcement action was necessary to compel the Department to produce records.<sup>3122</sup> However, he ultimately decided to instead insist on regular meetings with senior departmental representatives who acted as a clearinghouse for the information requests and status updates.<sup>3123</sup> The Registrar observed it was not until the second half of 2021 that information flow improved.<sup>3124</sup> We discuss this in Section 14.1.

Some senior departmental officials disagree there was ‘reluctance’ within parts of the Department to share records, at least on their own part.<sup>3125</sup> Ms Clarke and Ms Baker told us that it was not until August 2021 that the Registrar raised his concerns about the timeliness of the Department’s response, which was followed by a series of regular meetings initiated by the Department providing ‘a regular forum to address any concerns’, which they considered to be effective.<sup>3126</sup>

During our hearings, senior departmental officials told us that the delays in reporting to the Registrar were a function of the Department’s record-keeping practices and that its records remediation project, discussed in Section 13.2, resulted in the Department being able to respond to requests for information more efficiently.<sup>3127</sup> Ms Baker acknowledged that the Department needed to respond to the Registrar’s requests for information in a more timely manner, although noted that once this was brought to her attention, she met the Registrar within two days to address this issue.<sup>3128</sup> We were told, however, that the Department often experienced the same limitations with information as experienced by the Registrar, noting that it often had ‘non-specific allegations of concern, but without concrete information on which to make a decision’.<sup>3129</sup>

We identified multiple discrepancies between when agencies told us they had reported information to the Registrar and the information held by the Registrar. We have not been able to determine whether the differences were caused by errors in reporting, the receiving of information or the recording of this information. Nevertheless, we are concerned that the Registrar may not be aware of all relevant information and is not always receiving information as quickly as possible.

While we acknowledge the difficulties the Registrar faced in obtaining prompt and clear information to inform his decision making, based on our case examples, we consider the Registrar occasionally adopted too high an evidentiary threshold in assessing risk, rather than undertaking prospective risk assessment. We consider the Registrar is uniquely placed to put children's safety at the forefront of decision making and should consistently do so.

### **Finding—On occasion, the Registrar of the Registration to Work with Vulnerable People Scheme appeared to adopt too high an evidentiary threshold in assessing whether staff with allegations against them posed an unacceptable risk to children**

As we have emphasised throughout this case study, the Registrar plays a central role in responding to risks to children in institutional settings. Their primary focus is on protecting vulnerable people, including children, from risks of harm. While the Registrar is required to extend procedural fairness to parties subject to its decisions and should recognise the weight of decisions on the lives and livelihoods of registered individuals, the Registrar is not required to 'prove' or 'substantiate' allegations in the same way that an employer may need to so as to apply disciplinary sanctions (on the balance of probabilities) or police must so as to secure a criminal conviction (beyond reasonable doubt). Rather, the Registrar is required to undertake an assessment of future risk to vulnerable people, including children. We consider this gives the Registrar greater scope to act on concerning information that suggests risk, including considering patterns and coincidence in assessing a body of allegations, and a broad array of corroborative evidence. The Registrar must be enabled and willing to adopt this approach.

In our case examples, we observed that the Registrar sometimes imposed too high a threshold when assessing risks to children. We accept the evidence of the Registrar that his decision making was sometimes hampered by belated or incomplete information from the Department. However, we consider it important that the Registrar maintains a focus on future risk, unimpeded by industrial or union concerns.



We make a detailed recommendation regarding the statutory guidance which the Tasmanian Government should provide to the Registrar in respect of risk assessments in Chapter 18.

## 12 Department of Justice responses to National Redress Scheme claims

In Section 3.1.2, we described the processes the Department of Justice used to get information from agencies to respond to queries from the Scheme Operator of the National Redress Scheme. In Section 9.4, we also outlined how some Department of Communities processes for responding to sharing information requests from the Department of Justice improved from October 2020.

In this section, we discuss previous concerns raised about the Department of Justice's sharing of information received under the National Redress Scheme. We also explain that the Department of Justice does not have a process for making notifications to relevant agencies based on information it receives from the Scheme Operator related to National Redress Scheme claims.

### 12.1 Concerns with information sharing between the Department of Justice and the former Department of Communities

Before at least October 2020, the Department of Justice's practice was to only share a summary of the information it received from the Scheme Operator, unless and until an agency specifically requested more information.<sup>3130</sup> We were told that this was to reduce vicarious trauma on staff who may be responsible for reviewing the information.<sup>3131</sup>

In 2019, concerns were raised within the Department of Communities that the information provided to agencies by the Department of Justice in respect of at least some National Redress Scheme claims was not enough to facilitate a 'thorough investigation'.<sup>3132</sup> We also identified at least one example where the name of an alleged abuser was not included in the 'National Redress Scheme – Request for Information' form (despite being known to the Department of Justice), which limited the Department of Communities' ability to act on that information.<sup>3133</sup>

The State told us the Department of Justice changed its practice in October 2020 and now provides everything it holds in respect of each National Redress Scheme application to the relevant agency.<sup>3134</sup> Secretary Pervan also recalled discussions at a multi-agency meeting between the Department of Justice, the former Department of Communities and others on 7 December 2020 that he considered ultimately led to

changes to the amount of detail the Department of Justice would provide to agencies in respect of National Redress Scheme claims and how quickly the information was provided.<sup>3135</sup> Secretary Pervan also said that this meeting led to a new process for contacting redress applicants to gauge their willingness to participate in investigations (such as police investigations or disciplinary investigations initiated by a department).<sup>3136</sup> Secretary Pervan did not elaborate on the specifics of these changes.

We also received evidence about a cross-agency meeting on 8 December 2020 at which attendees discussed the need to ensure there was information sharing between agencies, including to identify whether an employee may have moved from one agency to another.<sup>3137</sup>

Given this evidence, we are unclear as to the timing of the change in the Department of Justice's practice but accept it occurred at some point in late 2020. We welcome this change.

We are concerned, however, that prior to at least October 2020 there was not a robust process for sharing information about National Redress Scheme claims that ensured all relevant information was provided to agencies completing a 'National Redress Scheme – Request for Information' form. As noted by Secretary Webster, the relevant agency is required to deal with allegations against current employees through its own internal policies.<sup>3138</sup> By not consistently providing complete information to the agency, this already challenging task became more difficult because of the fragmentation and omission of information. We would be concerned if a focus on protecting staff from trauma had a negative impact on the Department's ability to make an appropriate assessment about risks to children, noting staff trauma must and can be addressed in other ways. Adding an extra step of summarising material also created greater risks of delays.

## 12.2 Making reports and notifications

The Department of Justice is often the first Tasmanian agency to receive allegations through the National Redress Scheme, but we were told it does not take any steps to report these allegations to authorities, including Tasmania Police, Child Safety Services and the Registrar.<sup>3139</sup>

We asked Secretary Webster what action the Tasmanian Government takes regarding information acquired during the National Redress Scheme process, beyond responding to information requests from the Scheme Operator about individual applications, including whether reports are made to Child Safety Services or Tasmania Police.<sup>3140</sup> Secretary Webster told us in response on 20 June 2022:

The Department [of Justice] does not use the information obtained through redress applications for any purpose outside responding to the Scheme Operator save for reporting on de-identified figures in annual reports.

I am unable to comment on what other Tasmanian Government agencies do in respect of information acquired during the National Redress Scheme process with the exception of current employees who are alleged abusers are dealt with by internal Agency policies.<sup>3141</sup>

### 12.2.1 Reporting to Tasmania Police

We were told the Department of Justice does not report matters to Tasmania Police.<sup>3142</sup> The National Redress Scheme's *Operational Manual for Participating Institutions* states that the Scheme Operator will report certain information directly to law enforcement, so Tasmania Police would be notified directly of some matters ahead of the Department of Justice and could then activate its processes to share information with the Registrar and Child Safety Services, where relevant. Tasmania Police also told us that if it received a report from the Department of Justice this may result in some duplication. It also told us that if it received a report regarding a matter from the Department of Justice, without identifying particulars, it might need to contact the responsible agencies to seek similar additional identifying particulars as the Department of Justice might also request from those agencies.<sup>3143</sup>

Tasmania Police also told us that if it received a report from the Department of Justice this may result in some duplication. It also told us that if it received a report regarding a matter from the Department of Justice, without identifying particulars, it might need to contact the responsible agencies to seek similar additional identifying particulars as the Department of Justice might also request from those agencies.<sup>3144</sup>

While we accept that the Department of Justice is relying on the National Redress Scheme's *Operational Manual for Participating Institutions* as reason to not make notifications to Tasmania Police, we are not sufficiently confident in that process (and in Tasmania Police's systems to make appropriate notifications). For example:

- The Department of Communities told us it reported certain National Redress Scheme allegations to Tasmania Police in October 2020, but Tasmania Police told us it received this from the Scheme Operator in June 2021.<sup>3145</sup> There were delays in Tasmania Police referring these allegations to the Registrar. The Department of Justice will have had this information before the Department of Communities.
- The Abuse in State Care Program claims relating to Lester were provided to Tasmania Police in November 2020, but it took Tasmania Police 21 months (in August 2022) to forward these to the Registrar.<sup>3146</sup> While this information was not about a National Redress Scheme claim, it illustrates the risk of relying on police reporting to the Registrar.

In Chapter 12, we discuss this issue in more detail and recommend that the Tasmanian Government advocates for changes to the National Redress Scheme operating procedures.

## 12.2.2 Department of Justice reporting to the Registrar

We are also concerned about the fact that the Department of Justice does not report the information it receives from the Scheme Operator to the Registrar and consider this would, in some circumstances, be a breach of the Registration to Work with Vulnerable People Act.

We consider that the Department of Justice did not, at the introduction of the National Redress Scheme, have appropriate processes in place to maximise the information it received from the Scheme Operator to inform decision making by the Registrar. This compromised responses to allegations received about Ashley Youth Detention Centre staff, particularly in contributing to delays. While we welcome changes made in October 2020 to ensure agencies are provided with complete information received from the Scheme Operator, we consider the issue of the Department of Justice not making reports to be a continuing problem.

We were given the following reasons why the Department of Justice does not report information it receives to the Registrar:

- The Department of Justice would often not have enough information to make a meaningful report and agencies would be in a better position to make notifications, noting that National Redress Scheme claims do not consistently have clear information about the identity of an abuser.<sup>3147</sup>
- The Registrar may become aware via a notification from Tasmania Police before the Department of Justice receives it through the process described in Section 12.1, which makes the need for the Department of Justice to report redundant.<sup>3148</sup>
- Too many notifications, particularly if based on incomplete information, may overwhelm agencies (such as the Registrar) when they are not necessarily able to act on that information.<sup>3149</sup>

We were also told there was ambiguity around the Department of Justice's obligation to report to the Registrar prior to the legislative clarification from 1 February 2021. Noting that the Department has not changed its practice since that time, we do not consider this legal advice to be determinative but consider it does reflect an attitude within the Department of Justice that was overly cautious and conservative in its approach to making notifications. This is curious given the Registrar sits within the Department of Justice and, based on our case examples, the Registrar seemed to have adopted a broad interpretation around what could, and should, be reported.

As we describe in Sections 3.1.2 and 9.3, there was some confusion around when a reporting obligation arose before 1 February 2021, given the uncertainty about whether a 'finding' of reportable conduct had been made such that the obligation arose. We note that the Department of Justice received legal advice from the Office of the Solicitor-General in September 2018 that the making of a 'finding' following an investigation under

the *State Service Act 2000* was a prerequisite for the Department of Justice to make a report under section 53A of the Registration to Work with Vulnerable People Act (which imposes a duty to report concerns about a risk of harm to a child to the Registrar).<sup>3150</sup>

This obligation was clarified in the legislation in February 2021 to impose an obligation on a reporting body to notify the Registrar where it ‘becomes aware by any means, or suspects on reasonable grounds that a registered person has engaged, or may have engaged, in reportable behaviour’ (that being, in this instance, behaviour that poses a risk of harm to a child).<sup>3151</sup> As noted above, Secretary Webster’s evidence on 20 June 2022 was that the Department of Justice still did not report these National Redress Scheme allegations to the Registrar.

We also note that the Department of Justice was aware of the expansive interpretation given by the Registrar to the meaning of the word ‘finds’ before the legislative amendments in 2021, with the Department of Justice’s request for legal advice to the Office of the Solicitor-General of 15 August 2018 stating:

The word ‘finds’ is not defined in the Act. However, based on the object of the Act, the functions and powers of the Registrar under the Act, the purpose behind the amendment of the Act to insert section 53A, and the successful application to date of section 53A by other reporting bodies; it is the Registrar’s position that the word should be given its ordinary meaning such as: ‘to come upon by chance’, ‘to learn, attain or obtain by search or effort’, ‘to discover’.<sup>3152</sup>

This broad interpretation is consistent with advice given by the Registrar to the Department in mid-2020, as we discuss in Section 9.3.

The Department of Justice’s request for legal advice also indicates an appreciation of the ‘flexible approach’ provided for in the Second Reading Speech to the legislation, as well as the difficulties in requiring a finding to be made before reporting to the Registrar, stating:<sup>3153</sup>

If section 53A was interpreted with the narrow interpretation (ie ‘a finding’ as opposed to ‘finds’) and the Registrar were to wait until the reporting body made their own ‘finding’ on a matter prior to the information being reported then ... it could be a matter of months, if not years, until the matter is reported to the Registrar ...

The duty of reportable bodies to report behaviour is relevant to whether a person remains acceptable to work with vulnerable people. It is crucial for the purposes of monitoring and compliance that the Registrar is informed in real time of *any* behaviours that by definition, pose a risk of harm to vulnerable persons ...<sup>3154</sup>  
[Emphasis in source.]

Irrespective of whether there was a duty to report a risk of harm to a child before the legislative changes in February 2021, it would have been best practice to report information obtained through the redress scheme to the Registrar.<sup>3155</sup>

While we accept that the Department of Justice will not always have enough information to make a notification to the Registrar, where it does, we consider it should. This is because:

- This ensures the Registrar receives the information at the earliest opportunity and is 'on notice' to contact relevant agencies for further information, where needed.
- The Registrar has identified (described in Section 11) that there is a lack of consistency in the way different agencies and departments approach their reporting obligations; the Department of Justice reporting would go some way in standardising this. Our case examples revealed delays in the former Department of Communities making notifications to the Registrar that could have been avoided if the matter was already reported by the Department of Justice.
- The Scheme Operator's reports to Tasmania Police would not necessarily capture all the information that constitutes 'reportable behaviour', which is broader than the type of matters that constitute a criminal offence. We consider that the Scheme Operator, as an Australian Government agency, is not best placed to determine some of the criteria for reporting (for example, we consider it less likely to be aware of whether an alleged abuser is working with children compared with Tasmanian agencies).

We discuss this in greater detail, and make a recommendation in this regard, in Chapter 12.

### **Finding—The Department of Justice does not have an appropriate process to ensure information in National Redress Scheme applications is shared in a timely manner to protect children**

We are concerned that the Department of Justice does not appear to have a process for reporting allegations provided to it through the National Redress Scheme to the Registrar. As a reporting body under the Registration to Work with Vulnerable People Act, the Department of Justice is obliged to notify the Registrar of 'reportable behaviour'.<sup>3156</sup> We were surprised that the Department of Justice, which administers the Registration to Work with Vulnerable People Scheme, does not refer allegations received through the National Redress Scheme as a matter of course. Although it does not receive all information associated with each National Redress Scheme application from the Scheme Operator, it is well placed to make an initial notification to the Registrar if it has enough information to do so, to reduce any delay.

We consider the Department of Justice should have set up a process to immediately refer these matters to the Registrar where it has enough information to do so and made it clear to relevant agencies from which it was seeking further information that any other information or reportable conduct held or obtained by those departments should be reported separately to the Registrar. Delaying giving information to the Registrar delays the Registrar's ability to take appropriate steps for assessing a person's suitability to be working with children. It also relies on all other departments making notifications appropriately.

The Department of Justice also has reporting obligations to Tasmania Police and Child Safety Services. It should put in place a process for making all relevant reports.

## 13 2021—Departmental initiatives to improve records and processes

Below we outline some other initiatives progressed by the Department from 2021 to improve its responses to allegations of child sexual abuse by Ashley Youth Detention Centre staff. It will be recalled that our Commission of Inquiry was formally established by Order of the Governor of Tasmania on 15 March 2021.<sup>3157</sup>

### 13.1 January 2021—Multi-agency budget bid to improve records relating to child sexual abuse

During our public hearings, we were informed of a State Budget bid that was made to Cabinet in 2020 to seek funding for the State's response to our Commission of Inquiry, including a proposal to improve the quality and accuracy of records held that may relate to child sexual abuse.<sup>3158</sup> Following our hearings, we sought copies of relevant budget documentation supporting that proposal.<sup>3159</sup>

In January 2023, the State advised us that a 2020 multi-agency State Budget bid was prepared by the agencies that anticipated being most affected by our Inquiry's work.<sup>3160</sup> Those agencies were the former Department of Communities, Department of Education, Department of Health, Department of Justice and Department of Police, Fire and Emergency Management.<sup>3161</sup> We were told that, as part of this budget bid, the Department of Communities made a bid to Cabinet for a large-scale records remediation and centralisation of historical records.<sup>3162</sup> The budget bid to Cabinet was unsuccessful.<sup>3163</sup>

We have not reviewed the 2020 budget bid documentation, noting that these are subject to privilege on the basis that they are cabinet-in-confidence documents.<sup>3164</sup>



We discuss the Department’s records remediation project below, which eventually began in May 2021 following the approval of an internal budget bid.

## 13.2 May 2021—Departmental records remediation project

Throughout this case study, we have described significant problems with the quality and accessibility of the Department’s records. We know records are extremely important in child sexual abuse matters because they often provide an evidentiary basis for initiating legal, criminal or disciplinary actions. They also help victim-survivors understand important information about their past experiences, including the circumstances surrounding their abuse. As set out in the National Royal Commission report, inadequate records and record keeping have contributed to failures in identifying and responding to risks and incidents of child sexual abuse and have exacerbated distress and trauma for many victim-survivors.<sup>3165</sup>

We understand there have been significant delays in releasing files and documents to people who request them, such as former detainees. We were told there were more than 300 applications for personal files outstanding in March 2021 and, at that time, nearly a two-year wait time for these to be assessed and released.<sup>3166</sup>

After the broader budget bid discussed in Section 13.1 was unsuccessful, in or around May 2021, internal funding was approved to enable records remediation work to progress in the Department.<sup>3167</sup> The Department initiated the Records Digitisation and Remediation Project to centralise historical records from 2000 onwards (partly to support its responses to our Commission of Inquiry, noting our focus begins on this date).<sup>3168</sup> A team of eight people in the records area began the digitisation work and the Department’s legal services area was given resources to enable it to dedicate the time to process personal information and requests through the Right to Information Scheme.<sup>3169</sup>

Ms Baker said this was a ‘significant piece of work’ where the Department needed to ‘identify what record holdings that we had’, ‘catalogue those record holdings’ and ‘remediate and digitise those records’.<sup>3170</sup> She told us that this resulted in the Department having a ‘fuller set of information’ that it could then make available to Employment Direction No. 5 investigators and to the Registrar.<sup>3171</sup>

In relation to the release of client files, we understand that during the period from March 2021 to April 2022, there had been 312 applications for information processed and released. Another 86 applications remained outstanding as of April 2022, and the Department for Education, Children and Young People agreed that the team dealing with information requests would continue until November 2022 to allow the work to progress further.<sup>3172</sup>

We welcome the Department’s investment and improvements to record keeping and make further recommendations to strengthen the integrity of files and the thoroughness (and completeness) of attempts to locate and triangulate multiple sources of information containing allegations relating to staff in Chapter 12.

### **13.3 Mid-late 2021—More flowcharts are developed clarifying process for responding to allegations against staff**

From 2021 onwards, some additional flowcharts were developed to guide the Department’s responses to allegations received about staff more broadly, including notifications processes. We describe these flowcharts, and our reflections on them, below.

#### **13.3.1 Department of Communities flowchart: ‘Common Law Claim, State-based Redress (historical), National Redress Application or other information received by People and Culture’**

In Section 9.4, we describe a flowchart the Department developed in October 2020 for responding to information received through National Redress Scheme claims. In late 2021, the Department developed a new flowchart that aims to clarify the processes the Department follows on receiving allegations against current employees (whether under a civil claim, through a redress scheme or some other source).<sup>3173</sup> We understand this exists and applies in addition to the flowchart prepared in October 2020.

The 2021 flowchart provides that once information about allegations against staff is received through any means, People and Culture conducts a factual check of the alleged abuser’s employment details and undertakes a risk assessment. If there is an immediate risk of harm to children, the following steps are taken:

- Immediate action is taken to manage the risk (such as removal from the workplace or variation of duties).
- A verbal report is provided to the Secretary.
- The Head of the State Service is notified if the abuser is removed from the workplace and an Employment Direction No. 5—Breach of Code of Conduct investigation is likely.
- A preliminary assessment is conducted.<sup>3174</sup>

Where it is determined that there is no immediate risk to children and young people, People and Culture proceeds to conduct a preliminary assessment without taking the above steps.

In all cases, the Department notifies ‘relevant external bodies’, such as the Registrar and Tasmania Police, if required.<sup>3175</sup>

The flowchart indicates that the preliminary assessment includes considering the role of the employee, the nature (sexual or physical) and severity of the allegation, other prior matters, available records (such as incident reports and health records) and questioning other employees. Relevantly, the flowchart states:

- If there is information that the Secretary could use to form a reason to believe a breach of the State Service Code of Conduct may have occurred, a Minute is provided to the Secretary with a recommendation for investigation and suspension.<sup>3176</sup>
- If there is not enough information for the Secretary to form a reason to believe a breach of the Code of Conduct may have occurred, a Minute is provided to the Secretary with other recommended actions, including putting the allegations to the alleged abuser for response, varying their duties or taking no action.<sup>3177</sup>
- Where putting the allegations to the alleged abuser results in more information that the Secretary could use to form a reason to believe a breach of the Code of Conduct may have occurred, a Minute to the Secretary is provided with this recommendation. Where the alleged abuser provides no such further information, the Department keeps the allegations on file and closes the matter (which is reopened if more information is received).<sup>3178</sup>

### **13.3.2 State Service Management Office flowchart: ‘State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process’**

We were also provided with a flowchart titled ‘State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process’, which we were told was prepared by the State Service Management Office for agencies to implement.<sup>3179</sup> It is unclear when this flowchart was created, although the document we have been provided is dated 22 April 2021. We are unclear whether and how this relates to the flowchart discussed in Section 13.3.1.

This flowchart indicates the following:

- Where an agency is aware of an allegation, it conducts a preliminary assessment including an assessment of the ‘risk of an employee remaining in the workplace including duty of care and public perception’.<sup>3180</sup> The employee is directed to not attend the workplace.
- The agency informs the police via the approved template.<sup>3181</sup>

- The Head of Agency immediately notifies the Head of the State Service verbally of the allegation and preliminary assessment.<sup>3182</sup>
- The ‘ED5 investigation remains pending, awaiting Police advice (i.e. not commenced; or on hold if commenced)’.<sup>3183</sup> Once the police advise the agency that there is no further police action or charges laid, the agency proceeds with the formal Employment Direction No. 5 investigation, suspends the employee (where appropriate) and updates the ‘ED5 register’ (including to indicate that the police assessment is now complete).<sup>3184</sup>
- Where a formal investigation has begun, the Head of the State Service also notifies the Premier, and the Head of the State Service or Premier informs the Minister.<sup>3185</sup>

### 13.3.3 Our observations

While we commend efforts to clarify processes for responding to allegations of abuse, we still have some reservations about this guidance. We consider aspects of these guidance materials could be clarified and further strengthened. For example:

- It is unclear how various flowcharts (including those described in Section 13.3 and the October 2020 guidance on responding to National Redress Scheme claims) are intended to operate together, noting that they have slightly different wording, emphases and requirements. For example, the ‘State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process’ provides for both the Premier and the Minister to be advised, which is different from other guidance. A single source of guidance would be preferable.
- The guidance often lacks specific timeframes in respect of key activities—including the conduct of a preliminary assessment or investigation, or notifications to external agencies. Given the significant delays we observed, we consider this a significant omission.
- Enabling reliance on verbal reporting (to the Secretary, for example) risks incomplete records. Where a verbal report is made to the Secretary, we consider it should require a written report to follow as soon as possible in the interests of timely and accurate record keeping and to create greater accountability.
- It is not clear from the flowcharts exactly who is responsible for which tasks (for example, who is responsible for providing the verbal report to the Secretary). Given the confusion we observed about respective responsibilities on these matters, we consider it necessary for guidance to be explicit around the roles.
- The ‘State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process’ appears to give unqualified deference to Tasmania Police advice without any guidance on how to mitigate risk in the interim and to continue to actively engage with Tasmania Police to minimise delays.

- The ‘Common Law Claim, State-based Redress (historical), National Redress Application or other information received by People and Culture’ flowchart does not offer enough clarity on when informal practices (such as putting allegations to staff) are appropriate other than there being ‘insufficient information’. We acknowledge that there may be times when an informal approach is appropriate (such as when there is a first-time minor boundary breach by a staff member). We consider that the nature and number of allegations should be a key consideration as to whether such an informal process is appropriate. We also consider that all efforts should be taken to quickly gather information (including, for example, by seeking to engage with a complainant) before this course of action is taken. In all circumstances, the allegation and outcome of the process should be recorded on the employee’s personnel file.

## 14 2021–2022—The Department continues to respond to allegations against staff

We heard that the case examples of Ira, Lester and Stan reflected a significant learning curve for the Department and were assured things had since changed. For example, Ms Clarke told us:

... those three matters that you’re talking about from my perspective of the Deputy Secretary, the Department started to enter into really uncharted territory. I think it matured in its capacity very, very quickly, I think it was a team effort; of course, learning occurs in those circumstances, and those particular matters, I think, from that, what we actually did see is the Department mobilised. In response to, when a comparison between those and today, I actually think it’s vastly different.<sup>3186</sup>

We note some welcome improvements and investments in responding to allegations of child sexual abuse from late 2020 onwards. However, we observed continuing difficulties in the Department’s response to allegations made against other Ashley Youth Detention Centre staff in 2021 and 2022, when the Department continued to receive more allegations against staff.

We did not investigate more recent responses as closely because they arose after our Commission of Inquiry was established. Accordingly, we set out below only our high-level observations of these matters.

The Department told us that, as of 20 July 2021, it had received the following allegations in 2021:

- Sixteen National Redress Scheme claims contained allegations against Ashley Youth Detention Centre staff (or those of its predecessor, the Ashley Home for Boys), some of which contained multiple allegations against multiple staff, during the period from 1998 to 2009.<sup>3187</sup>
- One civil claim regarding Ashley Youth Detention Centre contained allegations against multiple staff members during the period from 2002 to 2008.<sup>3188</sup>
- There was an allegation made through the Department that a staff member had forcibly stripped a detainee during the period from 2015 to 2016.<sup>3189</sup>

At the time, the Department was aware of allegations included rape, sexual abuse while strip searching (including digital penetration of a detainee’s anus), being watched in the shower, being forced to watch staff members masturbate and the placement of lotion on detainees’ genitals.

We also received a spreadsheet from the Department that, based on our analysis of its content, states that in the period from 20 July 2021 to 25 May 2022, the Department received another 54 claims about child sexual abuse at Ashley Youth Detention Centre (six civil claims and 48 National Redress Scheme claims).<sup>3190</sup> Of the 54 claims received during this period, 51 claims named Ashley Youth Detention Centre staff members (or those of its predecessor, the Ashley Home for Boys) as alleged abusers and the allegations relate to conduct over the period from 1997 to as recently as 2019.<sup>3191</sup>

Further, we received evidence that suggests many more civil claims have been issued in relation to physical abuse at Ashley Youth Detention Centre, with a briefing for the Minister for Children and Youth dated 4 November 2021 stating that, as of 18 October 2021, there were 42 civil claims related to allegations of physical and/or child sexual abuse that involved the Department (or its predecessor).<sup>3192</sup>

Also, on 11 August 2022 a class action was commenced in the Supreme Court of Tasmania on behalf of more than 100 former Ashley Youth Detention Centre detainees, with more claimants being added at the time of writing.<sup>3193</sup> We discuss the allegations raised in this class action in Case study 1, but note briefly here that the lawyers acting for the plaintiffs in the class action, Angela Sdrinis Legal, told us that they act for more than 150 clients who allege abuse at Ashley Youth Detention Centre and its predecessor, and that complaints include allegations of child sexual abuse spanning 40 years.<sup>3194</sup>

As discussed in Section 9, the Department was aware that this class action was looming in 2020 and the impending class action was discussed at the Strengthening Safeguards Working Group meetings in late 2020.<sup>3195</sup>

Our analysis of the information provided to us indicates that in each of 2021 and 2022, the Department began Employment Direction No. 5—Breach of Code of Conduct investigations against and suspended four Ashley Youth Detention Centre employees (a total of eight suspensions over those two years).<sup>3196</sup>

In April 2022, the Department had also prepared a Minute recommending suspending and initiating an Employment Direction No. 5 investigation into another Ashley Youth Detention Centre employee, although this was ceased when the employee resigned.<sup>3197</sup> We understand that the Department began preliminary assessments for three more Ashley Youth Detention Centre employees but that these did not proceed to an Employment Direction No. 5 investigation or suspension and no further action was taken.<sup>3198</sup>

In August 2022, we heard that the Department had lowered the threshold required for triggering an Employment Direction No. 5 investigation where there was an allegation of child sexual abuse, and that a child raising an allegation would be much more likely to be regarded as ‘reasonable grounds’ for an investigation even before other extensive evidence was sought.<sup>3199</sup>

As of January 2023, there were 10 investigations under Employment Direction No. 5 that were outstanding, despite those investigations beginning between November 2020 and May 2022.<sup>3200</sup> Two other investigations had not been progressed because the employee resigned.<sup>3201</sup> Secretary Pervan told us that investigations have been prioritised but that they have ‘all taken an inordinate amount of time because for the most part the accused Officers have not readily participated in the process because they are on sick leave’.<sup>3202</sup> He said he did not have powers of compulsion and he believes that he is not able to make findings where there is not enough evidence, even if the accused does not participate.<sup>3203</sup>

## 14.1 Our observations of responses from 2021 onwards

As described above, we did not conduct a forensic analysis of departmental responses to allegations of abuse from 2021 onwards, but we did receive and consider some evidence about these responses regarding four Ashley Youth Detention Centre staff. Collectively, those cases involved three Abuse in State Care Program claims, seven National Redress Scheme claims, one civil claim, one complaint to Tasmania Police and one complaint raised by former Leader of the Tasmanian Greens, Cassy O’Connor. Allegations against these four staff members included that one or more of them had rubbed heat gel on children’s genitals as punishment, enabled and encouraged harmful sexual behaviours between detainees, raped one or more detainees and inappropriately strip searched or touched one or more detainees. There were also allegations of physical abuse and excessive uses of force.

Across that evidence, we observed the following themes that mirrored some of our concerns with the responses we saw in the Ira, Lester and Stan case examples. These included the following (across one or more cases):

- We noted delays and failures to reassign employees to other areas of work that did not involve any contact with detainees while a preliminary assessment or



investigation was underway. In one matter, we saw a willingness to delay decision-making on disciplinary action on the basis that detainees were sufficiently protected if the alleged abuser was in a non-operational role (but remained on site). In that case, People and Culture became aware (some months later) that the staff member was regularly entering accommodation units for certain purposes associated with their non-operational role, which was considered ‘a risk to the Agency’.<sup>3204</sup> The staff member was then suspended.<sup>3205</sup>

- The Department relied on informal processes for putting allegations to alleged abusers, instead of proceeding to an Employment Direction No. 5 investigation following a preliminary assessment. Such information processes fall outside the State Service disciplinary framework. This happened even in instances where there were numerous allegations that could have been treated as a potential pattern of behaviour that had cumulative weight and warranted further investigation and suspension while that investigation was undertaken.<sup>3206</sup> In one Minute to the Secretary, approved in mid-2021, we saw the process of putting allegations to the staff member described as an ‘opportunity to reinforce the correct standards of behaviour, operating procedures and policies’.<sup>3207</sup>
- Where allegations were put to alleged abusers, we observed an unwillingness to put all allegations known to the Department to alleged abusers. In one instance, we understand that the Department only put allegations of physical abuse to an alleged abuser but did not raise allegations of sexual abuse (which were numerous and severe in nature).<sup>3208</sup> We do not know why this approach was taken.
- There were often lengthy periods between receiving allegations, removing alleged abusers from the Centre and starting an Employment Direction No. 5 investigation—in one instance, more than a year and in another, just under a year.<sup>3209</sup>
- There was a failure on one occasion to act promptly on the rediscovery of an Abuse in State Care Program claim. In that instance, the claim was rediscovered in September 2020, but an Employment Direction No. 5 investigation did not begin until early 2022.<sup>3210</sup>
- We saw continued delays in making notifications to Tasmania Police and the Registrar (including of up to 11 months in one case and six months in another).
- In one instance, reference to the 2007 Solicitor-General’s advice was used to justify failing to pursue misconduct investigations, despite allegations having been received after December 2020 (being the month in which revised legal advice was received by the Department that permitted it to act).<sup>3211</sup>

We also observed, in one instance, an emphasis on concerns for employee morale and wellbeing, such that it was considered important for employees to continue to attend work even where serious allegations had been made against them.<sup>3212</sup> In that example, we saw references to the need to perform a ‘balancing act’ between detainee and staff safety.<sup>3213</sup> We were told that at this time there were very real risks to staff welfare, but that detainee safety was ‘always considered a paramount priority’.<sup>3214</sup>

We acknowledge that there have been several suspensions and staffing pressures over recent years and months at Ashley Youth Detention Centre. By this point, the Department was operating in uncharted and exceptional circumstances. There were several staff with allegations against them, and there were staff shortages and lockdowns (which adversely impact children and young people).

The Department was also facing the challenge that, with some allegations, there may have been little prospect of substantiation for a variety of reasons. When this occurs, it can lead to an (incorrect) assumption that the allegation was proven to be false. A non-finding can ‘vindicate’ the staff member in the eyes of their colleagues, reinforce negative attitudes towards current and former detainees and contribute to fears in current detention centre staff that they may be subject to false allegations. We accept that these are all difficult dynamics for the Department to manage and that care and judgment are required in responding to each matter.

While considerations of staff wellbeing should never come at the expense of the safety of children, often staff wellbeing and child safety go hand in hand. The safety and wellbeing of staff can have a direct (and indirect) impact on the collective safety and wellbeing of children and young people in their care.

In one case in late 2021 and early 2022, the Department received an allegation through a civil claim.<sup>3215</sup> The Department responded as follows:

- One week after receiving the civil claim, the claim was sent to Tasmania Police.<sup>3216</sup>
- Six weeks after receiving the civil claim, information arising from the claim was provided to People and Culture.<sup>3217</sup>
- Six weeks after information was provided to People and Culture, a preliminary assessment began.<sup>3218</sup>
- The staff member was suspended and an Employment Direction No. 5 investigation began within two days of starting the preliminary assessment.<sup>3219</sup>
- The Registrar was notified of the claims approximately four months after the Department received the allegations.<sup>3220</sup>

In another case in around mid-2022, the Department received allegations through the National Redress Scheme against a current staff member. Following this:

- The claim was provided to People and Culture approximately three weeks later.<sup>3221</sup>
- The preliminary assessment began on the day the claim was provided to People and Culture.<sup>3222</sup>
- The claim was sent to Tasmania Police and the Registrar the day after the claim was provided to People and Culture.<sup>3223</sup>
- The staff member was suspended and an Employment Direction No. 5 investigation launched two days after the claim was provided to People and Culture.<sup>3224</sup>

The above examples show some improvements in how allegations are managed, although also continuing delays in some areas. While we are concerned by some of the initial delays in referring matters to People and Culture, we can see some improvements in timeliness compared with the cases of Ira, Lester and Stan. However, these examples also show that delays in referrals to People and Culture led to delays in referring to Tasmania Police and the Registrar. We were also concerned to see that there were additional delays in reporting to the Registrar even after the referral had been made to People and Culture, with one claim being referred to the Registrar more than two months after it was provided to People and Culture. Ms Allen acknowledged that this was a concern and told us that systems and processes have now been implemented so that the legal team reports civil claims to the Registrar.<sup>3225</sup>

We consider this period continued to reveal a tension or ‘push–pull’ between prioritising risks to child safety and risks to staff morale and wellbeing. While in late 2020, concerns about child safety appeared to be dominant, by 2021 to 2022 concerns about staff morale re-emerged.<sup>3226</sup> This reflected a theme we identified in previous reviews and reports into Ashley Youth Detention Centre.<sup>3227</sup>

While we have highlighted continuing problems across responses to individual staff, ultimately, we consider this period confirms the emerging concerns of departmental officials from the 2019 to 2020 period—that there is a pattern of behaviour across multiple staff.

We consider that there may be times where the sheer number and nature of historical allegations (as is the case with Ashley Youth Detention Centre) may overwhelm the effectiveness of an individualised disciplinary approach and reach the level of what is, essentially, a catastrophic critical incident. We heard evidence to suggest that the number of staff being suspended due to allegations was compromising the safe operations of the Centre and highly damaging for the wellbeing of staff—not only because of increased workload pressure but also the broader instability, distress and fearfulness it created. Once such a catastrophic threshold is reached—as arguably it has at the Centre—we consider it in the interests of staff and detainees to initiate a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers and any other relevant staff, and that requires

them to reapply for their positions. This will allow reappointed current and new staff to be confident that the community will see them as part of the solution. We make such a recommendation in Chapter 12.

## 15 Conclusion

Across this case study we identified numerous problems with how the Department has responded to allegations of child sexual abuse perpetrated by staff, noting some different problems during varying periods.

From 2003 to 2013, the Department received multiple allegations of abuse through the Abuse in State Care Program, identified that several current staff were the subject of allegations, and received legal advice but did not take the steps outlined in that advice that may have enabled it to act on allegations received through that (and later) iterations of redress schemes and civil claims. We were told the practical effect of this advice constrained the Department up until 2020 from acting on information it received alleging abuses by staff at Ashley Youth Detention Centre.

In the years from 2007 to 2018, we saw a reluctance to consistently take formal disciplinary action against staff, with internal reviews and investigations that were not always appropriate given the severity or number of allegations against staff. The case example of Walter also highlighted problems in the Department's failure to consider the cumulative impact of allegations, including those through the Abuse in State Care Program. It also showed a concerning historical arrangement between the Office of the Ombudsman and Ashley Youth Detention Centre of referring matters back to the Centre, which appeared to capture more than minor matters and, at least on occasion, resulted in serious matters being erroneously referred back to the Centre. We were glad to hear this referral arrangement has since ceased.<sup>3228</sup>

From 2019, the Department started to receive a growing number of allegations through the National Redress Scheme and civil claims, as well as reidentifying previous Abuse in State Care Program allegations that had been lost to the Department's corporate memory over time. We examined the Department's response to this growth in allegations in detail because it is so recent and presents challenges the Department is still facing. In fact, we see the systemic issues uncovered in responding to National Redress Scheme claims as having potential national relevance in informing how this information can be employed to better protect children from abuse in institutions.

We identified multiple problems primarily centred around the delays in responding to allegations about three staff members—Ira, Lester and Stan. We discovered problems in not recognising the full range of conduct that may constitute child sexual abuse, poor record keeping, a lack of awareness and responsiveness to prior Abuse in State Care Program claims and inappropriate risk management strategies to protect children,

including leaving staff who were the subject of allegations on site. We also identified a conservative application of the disciplinary process, including not giving enough weight to child safety, not undertaking proper processes in response to serious allegations, and setting too high a threshold for taking disciplinary action even where there was a pattern of alleged misconduct against a staff member. There was an apparent lack of appetite for questioning these problems, taking decisive action or seeking legal advice to question perceived barriers until late 2020.

We also found there were problems with interagency responses during this time, particularly with the coordination and information sharing between the Department of Justice, the Department of Communities, Tasmania Police and the Registrar. We received no information demonstrating significant engagement or information sharing with Child Safety Services at all.

From late 2020 to 2021, we saw several system improvements to address many of these problems, including improved records management and information sharing. Despite these improvements, we remain concerned that there continue to be several challenges for responding to allegations made through redress schemes. In particular, the disciplinary process and the Registration to Work with Vulnerable People Scheme, or their application, do not appear well equipped to respond to these types of allegations.

We see the Registrar as best placed to overcome the challenge of managing allegations arising out of the National Redress Scheme—with its ability to prioritise child safety. However, this solution relies on the Registrar being enabled and willing to consider pattern and coincidence in assessing a body of allegations, considering a broad array of corroborative evidence.

In Chapter 12, we make a range of recommendations for reform that we trust will improve the way the Department and other agencies respond to allegations of abuse in youth detention more broadly. The most significant of these is our recommendation for initiating a considered change management process. Such a process will give children and young people, staff and the community confidence in Ashley Youth Detention Centre in the future.

# Notes

## Case study 3: Isolation in Ashley Youth Detention Centre

- 1531 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 15, 43, 90–91.
- 1532 Committee on the Rights of the Child, *General Comment No 24 (2019) on Children’s Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 16 [95](g).
- 1533 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1534 *Youth Justice Act 1997* s 133(1).
- 1535 *Youth Justice Act 1997* ss 124(2), 133(2); Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1536 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1537 *Youth Justice Act 1997* s 146B; Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1538 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1539 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1540 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1541 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1542 References to the detention Centre Manager regarding the use of isolation procedure should be taken as a reference to the ‘detention centre manager or their delegate’. Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1543 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1544 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1545 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1546 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1547 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1548 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1549 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1550 The Isolation Procedure refers to this role as ‘Director, Services to Young People’. As discussed in Chapter 10, this role has been known by different names and we have elected to refer to it as ‘Director, Strategic Youth Services’.
- 1551 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 4–6, produced by the Tasmanian Government in response to a Commission notice to produce.



- 1552 *Youth Justice Act 1997* s 133(5); Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1553 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1554 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1555 Department of Communities, 'Instrument of Revocation and Delegation – Detention Centre Manager', July 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1556 Department of Communities, 'Instrument of Revocation and Delegation – Detention Centre Manager', July 2019, 3, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1557 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce, 2.
- 1558 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1559 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1560 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1561 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1562 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1563 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1564 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1565 The names 'Ben' and 'Erin' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2; Transcript of 'Erin', 22 August 2022, 3020 [41–42].
- 1566 Statement of Brett Robinson, 2 June 2022, 5 [28]; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7.
- 1567 The names 'Charlotte', 'Fred' and 'Eve' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Charlotte', 31 January 2022, 3; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7; Statement of 'Fred', 24 August 2022, 2 [13]; Statement of 'Eve', 18 August 2022, 4 [20].
- 1568 Transcript of 'Erin', 22 August 2022, 3024 [12–15]. The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 1 [3].
- 1569 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2. The name 'Simon' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Simon', 7 July 2022, 1 [5]; Statement of Brett Robinson, 2 June 2022, 5 [30]; Statement of 'Charlotte', 31 January 2022, 3.
- 1570 Transcript of 'Fred', 25 August 2022, 3345 [27–31]; Statement of 'Max', 19 May 2022, 9 [40].
- 1571 Transcript of 'Erin', 22 August 2022, 3020 [41]–3021 [1]; Statement of 'Charlotte', 31 January 2022, 3; Statement of 'Eve', 18 August 2022, 3 [13].
- 1572 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2.
- 1573 The name 'Simon' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Simon', 7 July 2022, 1 [5].



- 1574 The name 'Erin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Transcript of 'Erin', 22 August 2022, 3020 [43–46].
- 1575 Transcript of 'Erin', 22 August 2022, 3020 [46]–3021 [1].
- 1576 Transcript of 'Simon', 18 August 2022, 2760 [1–10]; Statement of 'Simon', 7 July 2022, 3 [13].
- 1577 Transcript of 'Simon', 18 August 2022, 2760 [1–10].
- 1578 Transcript of 'Simon', 18 August 2022, 2758 [24–31].
- 1579 The name 'Fred' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of 'Fred', 25 August 2022, 3343 [42–46].
- 1580 Transcript of 'Fred', 25 August 2022, 3343 [42–46]; Statement of 'Fred', 24 August 2022, 3 [14].
- 1581 Transcript of 'Erin', 22 August 2022, 3024 [12–15].
- 1582 Statement of Brett Robinson, 2 June 2022, 5 [30].
- 1583 Statement of 'Erin', 18 July 2022, 6 [31].
- 1584 The name 'Oscar' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. In relation to Oscar, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged. Statement of 'Oscar', 29 July 2022, 3 [14]; Statement of Brett Robinson, 2 June 2022, 5 [28].
- 1585 Statement of 'Oscar', 29 July 2022, 2 [10].
- 1586 Statement of 'Simon', 7 July 2022, 3 [13].
- 1587 Statement of 'Max', 19 May 2022, 9 [40].
- 1588 Statement of Brett Robinson, 2 June 2022, 6 [31–32].
- 1589 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 6.
- 1590 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 6.
- 1591 The name 'Charlotte' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 1592 Statement of 'Charlotte', 31 January 2022, 3.
- 1593 Statement of 'Charlotte', 31 January 2022, 3.
- 1594 The names 'Eve' and 'Norman' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Eve', 18 August 2022, 3 [13].
- 1595 Statement of 'Eve', 18 August 2022, 3 [13].
- 1596 Statement of 'Eve', 18 August 2022, 4 [20].
- 1597 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 3 [18(b)].
- 1598 The name 'Digby' is a pseudonym. Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of 'Digby', 8 August 2022, 5 [18(c)]; Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].
- 1599 Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].
- 1600 Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].
- 1601 Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [32]; Statement of 'Digby', 8 August 2022, 17 [56(d)].
- 1602 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 6 [32].
- 1603 Statement of 'Digby', 8 August 2022, 17 [56(d)].
- 1604 Statement of 'Digby', 8 August 2022, 17 [56(d)]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].
- 1605 Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].
- 1606 Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].

- 1607 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [32]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [33]. The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 19 [90]; Anonymous Statement, 16 August 2022, 9 [41].
- 1608 Statement of Samuel Baker, 8 August 2022, 6 [48–49]; Transcript of Samuel Baker, 19 August 2022, 2908 [35]–2909 [10]; Anonymous Statement, 16 August 2022, 9 [41–42].
- 1609 Transcript of Samuel Baker, 19 August 2022, 2907 [24–44].
- 1610 Transcript of Colleen (Sue) Ray and Sarah Spencer, 18 August 2022, 2816 [27–34].
- 1611 Transcript of Pamela Honan, 19 August 2022, 2959 [7–9].
- 1612 Transcript of Pamela Honan, 19 August 2022, 2959 [11–19].
- 1613 Transcript of Madeleine Gardiner, 22 August 2022, 3006 [17–28].
- 1614 Email from former Manager, Professional Services and Policy, Ashley Youth Detention Centre to Patrick Ryan, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1615 Ashley Youth Detention Centre, 'Behaviour Development System, Version 2.2', May 2013, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1616 Ashley Youth Detention Centre, 'Behaviour Development System, Version 2.2', May 2013, 13, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1617 Transcript of Sarah Spencer, 18 August 2022, 2815 [1–3].
- 1618 Statement of former Operations Coordinator, Ashley Youth Detention Centre, 15 June 2022, 14.
- 1619 Statement of Madeleine Gardiner, 15 August 2022, 30 [53(d)].
- 1620 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 1621 Statement of 'Alysha', 16 August 2022, 18 [86].
- 1622 Transcript of Sarah Spencer, 18 August 2022, 2815 [35]–2816 [7].
- 1623 *Lusted v ZS* [2013] TASMC 38.
- 1624 *Lusted v ZS* [2013] TASMC 38, 5 [12–13].
- 1625 *Lusted v ZS* [2013] TASMC 38, 5 [11].
- 1626 *Lusted v ZS* [2013] TASMC 38, 7 [15]–9 [20].
- 1627 *Lusted v ZS* [2013] TASMC 38, 5 [12].
- 1628 *Lusted v ZS* [2013] TASMC 38, 5–6 [14].
- 1629 *Lusted v ZS* [2013] TASMC 38, 5–6 [14].
- 1630 *Lusted v ZS* [2013] TASMC 38, 7 [15].
- 1631 *Lusted v ZS* [2013] TASMC 38, 8 [16], 9 [18].
- 1632 *Lusted v ZS* [2013] TASMC 38, 10 [22].
- 1633 Letter from Mark Morrissey to Michael Pervan, 6 April 2016.
- 1634 Letter from Mark Morrissey to Michael Pervan, 6 April 2016, 2–3.
- 1635 Letter from Mark Morrissey to Michael Pervan, 6 April 2016, 3.
- 1636 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1637 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1638 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1639 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1640 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1641 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1642 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1643 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1644 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1645 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1646 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1647 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1648 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1649 Letter from Michael Pervan to Mark Morrissey, undated.
- 1650 Email from Mark Morrissey to Acting Deputy Secretary for Children and Youth Services, 9 November 2016, 2–3.
- 1651 Email from Mark Morrissey to Acting Deputy Secretary for Children and Youth Services, 9 November 2016, 2–3.
- 1652 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.
- 1653 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.
- 1654 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.
- 1655 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.
- 1656 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1–2.
- 1657 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1658 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1659 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1660 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1661 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1662 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.
- 1663 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.
- 1664 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.
- 1665 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.
- 1666 Email from Mark Morrissey to Acting Deputy Secretary for Children, 4 January 2017, 2.

- 1667 Email from Mark Morrissey to Acting Deputy Secretary for Children, 4 January 2017, 2.
- 1668 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017.
- 1669 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017, 1–2.
- 1670 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017, 1.
- 1671 Email from Mark Morrissey to Acting Deputy Secretary for Children, 11 January 2017, 1.
- 1672 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.
- 1673 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.
- 1674 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.
- 1675 Email from Mark Morrissey to Richard Connock, 9 February 2017.
- 1676 Email from Mark Morrissey to Richard Connock, 9 February 2017.
- 1677 Email from Mark Morrissey to Ginna Webster, 2 June 2017, 1.
- 1678 Email from Mark Morrissey to Ginna Webster, 2 June 2017, 1.
- 1679 Statement of Mark Morrissey, 9 August 2022, 1 [3]; Transcript of Mark Morrissey, 18 August 2022, 2781 [40]–2783 [5].
- 1680 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.
- 1681 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce; *Youth Justice Act 1997* s 124(2).
- 1682 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019).
- 1683 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019) 1.
- 1684 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019) 53–55.
- 1685 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019) 54.
- 1686 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘All Young People Communication’, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1687 Email from Patrick Ryan to Ashley Professional Services staff copied to Greg Brown, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘All Young People Communication’, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1688 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1689 Ashley Youth Detention Centre, ‘Blue Colour Category Purpose and Practices’, undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).
- 1690 Ashley Youth Detention Centre, ‘Blue Colour Category Purpose and Practices’, undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Blue Colour Category Details’, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1691 Ashley Youth Detention Centre, ‘Blue Colour Category Purpose and Practices’, undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).
- 1692 Ashley Youth Detention Centre, ‘Blue Colour Category Purpose and Practices’, undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).
- 1693 Ashley Youth Detention Centre, ‘Blue Colour Category Purpose and Practices’, undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1694 Ashley Youth Detention Centre, 'Blue Colour Category Details', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1695 Ashley Youth Detention Centre, 'Blue Colour Category Details', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1696 Patrick Ryan, 'Blue All Young People Communication', 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Patrick Ryan, 'Blue Colour All Staff Communication', 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1697 Transcript of Patrick Ryan, 7 September 2022, 3607 [35–40].
- 1698 Transcript of Patrick Ryan, 7 September 2022, 3607 [26]–3608 [46].
- 1699 Transcript of Patrick Ryan, 7 September 2022, 3607 [26]–3608 [46].
- 1700 Statement of Patrick Ryan, 18 August 2022, 10 [99]; Statement of Patrick Ryan, 18 August 2022, Annexure to question 23, 128–130.
- 1701 Statement of Patrick Ryan, 18 August 2022, 10 [99].
- 1702 Statement of Patrick Ryan, 18 August 2022, 10 [102].
- 1703 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 March 2019, 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1704 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 18 March 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 25 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1705 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 18 March 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 25 March 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 1 April 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1706 Email from Patrick Ryan to Greg Brown, 15 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Patrick Ryan to Greg Brown, 18 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Patrick Ryan to Greg Brown, 2 April 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1707 Statement of Greg Brown, 28 November 2022, 19 [56].
- 1708 Statement of Greg Brown, 28 November 2022, 18 [54].
- 1709 Statement of Greg Brown, 28 November 2022, 21 [61].
- 1710 State of Tasmania, *Procedural Fairness Response*, 16 July 2023, 3; Michael Pervan, *Procedural Fairness Response*, 21 July 2023, 4.
- 1711 Email from Leanne McLean to Patrick Ryan, 4 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1712 Email from Patrick Ryan to Leanne McLean, 4 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1713 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1714 Email from Patrick Ryan to Leanne McLean, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce. For completeness, Mr Ryan refers to the incident occurring on 25–26 'March' but given the date of his correspondence, this is likely an error.
- 1715 The name 'Piers' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Email from Patrick Ryan to 'Piers', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1716 Transcript of Patrick Ryan, 7 September 2022, 3624 [31–35].



- 1717 Transcript of Patrick Ryan, 7 September 2022, 3624 [26–29].
- 1718 Transcript of Patrick Ryan, 7 September 2022, 3623 [45–47].
- 1719 Email from Patrick Ryan to Leanne McLean, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1720 Statement of Patrick Ryan, 18 August 2022, 10 [101]; Transcript of Patrick Ryan, 7 September 2022, 3609 [1–3].
- 1721 Statement of Madeleine Gardiner, 15 August 2022, 23 [38], 30 [53(d)].
- 1722 Statement of Madeleine Gardiner, 15 August 2022, 22 [37], 23 [38], 30 [53(d)].
- 1723 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [46]–3009 [2]; Statement of Madeleine Gardiner, 15 August 2022, 30 [53(d)].
- 1724 Ashley Youth Detention Centre, ‘Draft BDS Review Committee Minutes’, 16 November 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Draft BDS Review Committee Minutes’, 22 January 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Draft BDS Review Committee Minutes’, 19 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1725 Ashley Youth Detention Centre, ‘Draft BDS Review Committee Minutes’, 19 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1726 The name ‘Digby’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of ‘Digby’, 8 August 2022, 13 [41]; Email from ‘Digby’ to Patrick Ryan, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1727 Email from ‘Digby’ to Patrick Ryan, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1728 Email from Patrick Ryan to Greg Brown, 12 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1729 Patrick Ryan, ‘Draft Issues Briefing for the Minister’, 12 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1730 Patrick Ryan, *Procedural Fairness Response*, 12 July 2023, 2.
- 1731 Statement of Madeleine Gardiner, 15 August 2022, Attachment 8, 1.
- 1732 Statement of Madeleine Gardiner, 15 August 2022, 31 [53(i)].
- 1733 Statement of Madeleine Gardiner, 15 August 2022, 23 [38].
- 1734 Statement of Madeleine Gardiner, 15 August 2022, 23 [38]; Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.
- 1735 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 2.
- 1736 Transcript of Madeleine Gardiner, 22 August 2022, 3006 [39].
- 1737 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.
- 1738 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.
- 1739 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [1–6]; Statement of Madeleine Gardiner, 15 August 2022, 23 [38].
- 1740 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [1–2].
- 1741 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [6–19].
- 1742 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [2–8].
- 1743 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [10–44].
- 1744 Transcript of Patrick Ryan, 7 September 2022, 3609 [31–37].
- 1745 Email from Greg Brown to Madeleine Gardiner, 21 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Ginna Webster, 29 April 2022, 1 [7]. We discuss the Department’s Quality Improvement and Workforce Development team in Chapter 9.

- 1746 Email from Greg Brown to Madeleine Gardiner, 21 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1747 Statement of Ginna Webster, 13 January 2023, 44 [72].
- 1748 Letter from Leanne McLean to Ginna Webster, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1749 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1750 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1751 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1752 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1753 Email from Administrative Support Officer, Commissioner for Children and Young People to CTECC, Department of Communities, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Executive Officer, Strategic Youth Services to Patrick Ryan and Madeleine Gardiner, 29 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1754 Email Patrick Ryan to former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 4 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1755 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1756 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1757 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1758 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1764 Statement of Michael Pervan, 24 August 2022, Annexure MP.77.001 ('Ashley Youth Detention Centre – Unit Bound Policy', Issues Briefing to Secretary, Department of Communities, 11 September 2019).



- 1765 Letter from Michael Pervan to Leanne McLean, 11 September 2019.
- 1766 Letter from Michael Pervan to Leanne McLean, 11 September 2019, 1.
- 1767 Letter from Michael Pervan to Leanne McLean, 11 September 2019, 1.
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- 1772 James Cumming Investigation Report, 94.
- 1773 The names 'Arlo', 'Elijah' and 'Joseph' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. James Cumming Investigation Report, 1.
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- 1775 James Cumming Investigation Report, 6–11, and 21–23.
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- 1777 James Cumming Investigation Report, 13.
- 1778 James Cumming Investigation Report, 12–13, 25, 67.
- 1779 James Cumming Investigation Report, 12.
- 1780 James Cumming Investigation Report, 10–11.
- 1781 James Cumming Investigation Report, 18.
- 1782 Department of Communities, 'Issues Briefing for the Minister: AYDC Incident – 13 December 2019', 7 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; James Cumming Investigation Report, 18.
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- 1793 James Cumming Investigation Report, 15.
- 1794 James Cumming Investigation Report, 15.
- 1795 James Cumming Investigation Report, 15.
- 1796 James Cumming Investigation Report, 16.
- 1797 James Cumming Investigation Report, 47–49.

- 1798 James Cumming Investigation Report, 47–49.
- 1799 James Cumming Investigation Report, 47–49.
- 1800 James Cumming Investigation Report, 37–38.
- 1801 James Cumming Investigation Report, 78–79.
- 1802 James Cumming Investigation Report, 47–49.
- 1803 James Cumming Investigation Report, 106.
- 1804 James Cumming Investigation Report, 37 [69].
- 1805 James Cumming Investigation Report, 16.
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- 1815 Statement of Michael Pervan, 24 August 2022, 65 [268–269].
- 1816 Statement of Michael Pervan, 24 August 2022, 65 [269].
- 1817 Statement of Mandy Clarke, 19 August 2022, 19 [82].
- 1818 Statement of Mandy Clarke, 19 August 2022, 19 [82].
- 1819 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.
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- 1821 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.
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- 1830 James Cumming Investigation Report, 112.
- 1831 James Cumming Investigation Report, 113.
- 1832 James Cumming Investigation Report, 113.
- 1833 Statement of Pamela Honan, 18 August 2022, 39 [61.3]; Statement of Pamela Honan, 18 August 2022, Attachment 18 (Email from Patrick Ryan to Maude and Piers, 16 January 2020) 1.
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- 1858 James Cumming Investigation Report, 96–97.
- 1859 James Cumming Investigation Report, 36 [56], 43 [25].
- 1860 James Cumming Investigation Report, 114.
- 1861 James Cumming Investigation Report, 78–79.
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- 1863 James Cumming Investigation Report, 44, 55, 101–102.
- 1864 James Cumming Investigation Report, 96, 106–107.
- 1865 James Cumming Investigation Report, 46.
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- 1867 James Cumming Investigation Report, 40, 55.
- 1868 James Cumming Investigation Report, 79, 97.
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- 1886 Statement of Jacqueline Allen, 15 August 2022, Attachment B Q23–25 ('Meeting to Discuss the Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 11 February 2022) 1.
- 1887 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.
- 1888 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.
- 1889 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.
- 1890 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.
- 1891 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 1.
- 1892 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 6.
- 1893 Statement of Jacqueline Allen, 15 August 2022, Attachment E Q23–25 (Letter from Michael Pervan to Patrick Ryan, 4 April 2022) 2–3.
- 1894 Statement of Jacqueline Allen, 15 August 2022, Attachment G Q23–25 (Letter from Michael Pervan to Chester, 28 September 2021) 1.
- 1895 Statement of Jacqueline Allen, 15 August 2022, Attachment G Q23–25 (Letter from Michael Pervan to Chester, 28 September 2021) 1.
- 1896 Statement of Jacqueline Allen, 15 August 2022, 34 [190].
- 1897 Statement of Jacqueline Allen, 15 August 2022, 34 [188].
- 1898 Statement of Jacqueline Allen, 15 August 2022, 34 [191].
- 1899 Statement of Pamela Honan, 18 August 2022, 40 [63.4].
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- 1901 Statement of Pamela Honan, 18 August 2022, 40 [63.4(c)].
- 1902 Statement of Pamela Honan, 18 August 2022, 41 [64.2].
- 1903 Statement of Pamela Honan, 18 August 2022, 41 [64.3].
- 1904 Statement of Pamela Honan, 18 August 2022, 41 [64.4].
- 1905 Transcript of Pamela Honan, 19 August 2022, 2959 [24–25].

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- 1907 Transcript of Michael Pervan, 25 August 2022, 3455 [33–37].
- 1908 Statement of Michael Pervan, 24 August 2022, 67 [276].
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- 1945 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').
- 1946 Email from Ashley Youth Detention Centre staff member to Ashley Youth Detention Centre Operations Management, 7 March 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1947 Former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 'Family Contact Information', 6 March 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1948 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').
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- 1960 Statement of Patrick Ryan, 18 August 2022, 29 [270]; Email from Patrick Ryan to Pamela Honan, 6 March 2020.
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- 1963 Statement of Pamela Honan, 18 August 2022, 48 [73.3].
- 1964 Statement of Pamela Honan, 18 August 2022, Annexure 23 (Email from Patrick Ryan to Pamela Honan, 6 March 2020), Annexure 24 (Emails from Patrick Ryan to Pamela Honan, 6 March 2020).
- 1965 Statement of Pamela Honan, 18 August 2022, 48 [73.3]; Transcript of Pamela Honan, 19 August 2022, 2965 [1–3].
- 1966 Statement of Pamela Honan, 18 August 2022, Annexure 23 (Email from Patrick Ryan to Pamela Honan, 6 March 2020).
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- 1971 Statement of Pamela Honan, 18 August 2022, Annexure 24 (Email from Patrick Ryan to Pamela Honan, 6 March 2020). Refer also to Statement of Pamela Honan, 18 August 2022, 48 [73.4].
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- 1992 'Ashley Youth Detention Centre Incident Report', 8 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce. Note that the original wording here refers to 'Saturday morning 8<sup>th</sup> of March'; this is considered an error.
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- 2000 Transcript of Pamela Honan, 19 August 2022, 2967 [29]–2969 [6].
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- 2002 Transcript of Pamela Honan, 19 August 2022, 2967 [24–27].
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- 2004 Janise Mitchell, 'Through the Fence and into Their Lives: Ashley Youth Detention Centre Trauma Informed Practice Framework, Discovery Phase, April 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2010 Statement of Michael Pervan, 27 July 2022, 72 [247].

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- 2012 Statement of Michael Pervan, 27 July 2022, 73 [249].
- 2013 Statement of Michael Pervan, 24 August 2022, 62 [256].
- 2014 Statement of Michael Pervan, 24 August 2022, 62 [257].
- 2015 Statement of Michael Pervan, 24 August 2022, 62 [257].
- 2016 Statement of Michael Pervan, 24 August 2022, 63 [258].
- 2017 Statement of Michael Pervan, 24 August 2022, 63 [259].
- 2018 Statement of Michael Pervan, 24 August 2022, 64 [263].
- 2019 Statement of Michael Pervan, 24 August 2022, 64 [264–265].
- 2020 Transcript of Michael Pervan, 26 August 2022, 3531 [21–29].
- 2021 Transcript of Pamela Honan, 19 August 2022, 2960 [6–9].
- 2022 Statement of Fiona Atkins, 15 August 2022, Annexure L ('Standard Operating Procedure #15 Isolation', 12 March 2015) 2.
- 2023 United Nations Committee against Torture, *Concluding Observations on the Sixth Periodic Report of Australia*, UN Doc C/AUS/CO/6 (5 December 2022) 11 [37].
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#### Case study 4: Use of force in Ashley Youth Detention Centre

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- 2037 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 43.
- 2038 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 29.
- 2039 Donald Palmer, Valerie Feldman and Gemma McKibbin, *The Role of Organisational Culture in Child Sexual Abuse in Institutional Contexts* (Final Report to the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016) 38.
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- 2044 Committee on the Rights of the Child, *General Comment No. 24 (2019) on Children's Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 16 [95](f); Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/28/68 (5 March 2015) 21 [86](f).
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- 2066 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7.

- 2067 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7.
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- 2073 Statement of 'Ben', 29 March 2022, 5 [22], Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 5.
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- 2075 Statement of 'Ben', 29 March 2022, 4 [18–19].
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- 2077 Transcript of 'Simon', 18 August 2022, 2757 [32–37].
- 2078 Statement of 'Simon', 7 July 2022, 2 [9]; Transcript of 'Simon', 18 August 2022, 2757 [33].
- 2079 Statement of 'Simon', 7 July 2022, 3 [11].
- 2080 Transcript of 'Simon', 18 August 2022, 2758 [38–43].
- 2081 Statement of 'Simon', 7 July 2022, 3 [11].
- 2082 Statement of 'Simon', 7 July 2022, 3 [14].
- 2083 The names 'Max', 'Warren' and 'Oscar' are pseudonyms; Order of the Commission of Inquiry, restricted publication orders, 18 August 2022 and 30 August 2023. Statement of 'Max', 19 May 2022, 8 [33]; Statement of 'Warren', 19 May 2022, 3 [16]; Statement of 'Oscar', 29 July 2022, 2 [11]. In relation to Oscar, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged.
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- 2095 Statement of 'Oscar', 29 July 2022, 2 [6]; Transcript of 'Erin', 22 August 2022, 3026 [29–41]; Statement of 'Max', 19 May 2022, 4 [20–21].
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- 2103 Transcript of Brett Robinson, 17 June 2022, 1542 [34]–1543 [1].
- 2104 Statement of Brett Robinson, 2 June 2022, 4–5 [24].
- 2105 Statement of Brett Robinson, 2 June 2022, 5 [24].
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- 2107 Transcript of 'Erin', 22 August 2022, 3027 [23–27]; File note of telephone conversation from the Commission of Inquiry to 'Erin', 18 July 2023.
- 2108 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 7 [31].
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- 2111 Statement of 'Max', 19 May 2022, 9 [39–40].
- 2112 Statement of 'Max', 19 May 2022, 9 [40].
- 2113 Department of Health and Human Services, 'Report to the Minister for Human Services – Ashley Youth Detention Centre, Review of Incidents 14–15 July 2016', 19 August 2016, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2114 Department of Health and Human Services, 'Report to the Minister for Human Services – Ashley Youth Detention Centre, Review of Incidents 14–15 July 2016', 19 August 2016, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health and Human Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, produced by the Tasmanian Government in response to a Commission notice to produce; WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2123 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 25–26, produced by the Tasmanian Government in response to a Commission notice to produce.





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- 2164 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

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- 2176 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2177 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2180 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2182 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce. Note that the review appears to identify this incident as occurring in December 2018, not December 2017. Given the date of the other incidents and the date of the review, we consider this is an error.
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- 2189 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2190 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2192 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2201 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2202 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 12, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2203 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2204 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2205 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 7–8, produced by the Tasmanian Government in response to a Commission notice to produce.

- 2206 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce. This is a reference to Heather Harker, 'Independent Review of Ashley Youth Detention Centre, Tasmania', June 2015, 2.
- 2207 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis omitted) quoting *The Ashley+ Approach Custodial Youth Justice Organisational Change Program*, 15.
- 2208 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2209 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2210 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2211 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2212 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2213 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

### Case study 5: A response to staff concerns about Ashley Youth Detention Centre

- 2214 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 5 [18].
- 2215 Statement of 'Alysha', 16 August 2022, Attachment A-1 ('Statement of Duties: Clinical Practice Consultant and Support Office', Department of Communities, August 2018).
- 2216 Statement of 'Alysha', 16 August 2022, 79 [402].
- 2217 Now the Department for Education, Children and Young People.
- 2218 The name 'Lester' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2219 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 3, 5.
- 2220 Statement of 'Alysha', 16 August 2022, 81 [414].
- 2221 Statement of 'Alysha', 16 August 2022, 85 [430].
- 2222 Statement of 'Alysha', 16 August 2022, 83 [422].
- 2223 Statement of 'Alysha', 16 August 2022, 5 [19].
- 2224 Peter Gutwein, 'Independent Review Confirmed' (Media Release, 8 September 2021) <[https://www.premier.tas.gov.au/site\\_resources\\_2015/additional\\_releases/independent\\_review\\_confirmed](https://www.premier.tas.gov.au/site_resources_2015/additional_releases/independent_review_confirmed)>.
- 2225 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2226 *Youth Justice Act 1997* ss 3 (definition of 'guardian'), 83(3).
- 2227 *Youth Justice Act 1997* s 124(1).
- 2228 Statement of Pamela Honan, 18 August 2022, 1 [1.2.3].

- 2229 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021.
- 2230 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 1–5.
- 2231 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 7–9.
- 2232 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 5–9.
- 2233 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021; Statement of Department for Education, Children and Young People, 6 February 2023, 22.
- 2234 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022).
- 2235 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 2 [5–6].
- 2236 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 16.
- 2237 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 16 [58–60].
- 2238 Statement of Kathy Baker, 18 August 2022, 31 [180(a)].
- 2239 Department of Communities, ‘Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan’, 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2240 Department of Communities, ‘Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan’, 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2241 Department of Communities, ‘Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan’, 28 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2242 Department of Communities, ‘Draft Issues Briefing to Minister: Update on AYDC Matters Referred by Cassy O’Connor’s Office’, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2243 Department of Communities, ‘Preliminary Assessment of Complaint Made by [‘Alysha’] Regarding Pamela Honan’, 28 March 2022, 1 [1–2], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2244 Letter from Kathy Baker to ‘Alysha’, 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2245 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2246 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2247 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, 16, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2248 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, 17, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2249 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, 17–18, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2250 Melanie Bartlett, ‘Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as “Alysha”’, 22 October 2021, 5, produced by the Tasmanian Government in response to a Commission notice to produce.



- 2251 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 35–36, 60, 63, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2252 Statement of 'Alysha', 16 August 2022, 85 [430].
- 2253 Statement of Mandy Clarke, 19 August 2022, 14 [46.1].
- 2254 Transcript of Mandy Clarke, 25 August 2022, 3435 [22–23].
- 2255 Statement of Kathy Baker, 18 August 2022, 31 [176].
- 2256 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2257 Transcript of Mandy Clarke, 25 August 2022, 3435 [13–26].
- 2258 Statement of Kathy Baker, 18 August 2022, 30–1 [176].
- 2259 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2260 Statement of Kathy Baker, 18 August 2022, 23 [128].
- 2261 Statement of Kathy Baker, 18 August 2022, 23–24 [131]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.
- 2262 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2263 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2264 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2265 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2266 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2267 Request for statement served on Michael Pervan, 2 August 2022, 18 [46(o)]; Request for statement served on Mandy Clarke, 2 August 2022, 18 [46(o)]; Request for statement served on Kathy Baker, 2 August 2022, 18 [46(o)].
- 2268 Statement of Michael Pervan, 24 August 2022, [164].
- 2269 Statement of Mandy Clarke, 19 August 2022, 15 [47].
- 2270 Transcript of Mandy Clarke, 25 August 2022, 3435 [13–26].
- 2271 Statement of Kathy Baker, 18 August 2022, 30 [176].
- 2272 Statement of Department for Education, Children and Young People, 6 February 2023, 41 [6.1].
- 2273 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2274 Request for statement served on Michael Pervan, 2 August 2022, 16–18 [46]; Request for statement served on Mandy Clarke, 2 August 2022, 16–18 [46]; Request for statement served on Kathy Baker, 2 August 2022, 16–18 [46].
- 2275 Statement of Michael Pervan, 24 August 2022, [158].
- 2276 Request for statement served on Mandy Clarke, 2 August 2022, 16–18 [46].
- 2277 Statement of Mandy Clarke, 19 August 2022, 13 [45].

- 2278 Mandy Clarke, *Procedural Fairness Response*, 13 July 2023.
- 2279 Statement of Kathy Baker, 18 August 2022, 31 [180(c)].
- 2280 Request for statement served on State of Tasmania, 19 October 2022, 5–6 [3].
- 2281 Statement of the Department for Education, Children and Young People, 6 February 2023, 32–33.
- 2282 Statement of Kathy Baker, 18 August 2022, 31 [180]; Statement of Mandy Clarke, 19 August 2022, 15 [48].
- 2283 Statement of Department for Education, Children and Young People, 6 February 2023, 32–33 [18].
- 2284 Statement of Department for Education, Children and Young People, 6 February 2023, 32–33.
- 2285 Statement of Kathy Baker, 18 August 2022, 15 [82(a)].
- 2286 Statement of Jacqueline Allen, 15 August 2022, 42 [233].
- 2287 Statement of Jacqueline Allen, 15 August 2022, 43 [236], 47 [274–279].
- 2288 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3442 [18–21].
- 2289 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 6–7.
- 2290 Letter from Kathy Baker to ‘Alysha’, 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2291 Statement of Kathy Baker, 18 August 2022, 31 [180(a)].
- 2292 Statement of Kathy Baker, 18 August 2022, 31 [180(b)].
- 2293 Department of Communities, ‘Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan’, 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Kathy Baker, 18 August 2022, 31–32 [180].
- 2294 Statement of Kathy Baker, 18 August 2022, 31 [180(c)]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 12.
- 2295 Statement of Kathy Baker, 18 August 2022, 31 [180(d)].
- 2296 Statement of Kathy Baker, 18 August 2022, 32 [180(f)–180(g)].
- 2297 Letter from Kathy Baker to ‘Alysha’, 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2298 Statement of Department for Education, Children and Young People, 6 February 2023, 22 [2].
- 2299 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.
- 2300 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.
- 2301 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.
- 2302 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.
- 2303 Statement of Michael Pervan, 24 August 2022, [166(i)].
- 2304 Statement of Kathy Baker, 18 August 2022, 31 [180].
- 2305 Statement of Mandy Clarke, 17 August 2022, 1.
- 2306 Statement of Mandy Clarke, 19 August 2022, 15 [46.11].
- 2307 Statement of Kathy Baker, 18 August 2022, 32 [181].
- 2308 Statement of Kathy Baker, 18 August 2022, 32 [182].
- 2309 Statement of Kathy Baker, 18 August 2022, 32 [181], 33 [187].
- 2310 Minister administering the *State Service Act 2000*, *Employment Direction No. 5: Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct* (13/3512, 4 February 2013) cl 7.1; Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9; Statement of Jacqueline Allen, 15 August 2022, 47 [274].
- 2311 Statement of Jacqueline Allen, 15 August 2022, 46 [273].
- 2312 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.
- 2313 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.
- 2314 Statement of Mandy Clarke, 19 August 2022, 14 [46.2].



- 2315 Department of Communities, 'Preliminary Assessment of Complaint made by [Alysha] regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2316 Statement of Michael Pervan, 24 August 2022, [158].
- 2317 Statement of Kathy Baker, 18 August 2022, 29 [168].
- 2318 Statement of Mandy Clarke, 19 August 2022, 14 [46.5].
- 2319 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [43–44].
- 2320 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [44–45].
- 2321 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [46–47].
- 2322 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3441 [19–21].
- 2323 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.
- 2324 Department of Communities, 'Preliminary Assessment of Complaint made by [Alysha] regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2325 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).
- 2326 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).
- 2327 The name 'Ira' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).
- 2328 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).
- 2329 Email from Manager, Human Resources and Workplace Relations, Department of Communities to 'Alysha', 9 January 2020.
- 2330 Email from 'Alysha' to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.
- 2331 Statement of Kathy Baker, 18 August 2022, 24 [135].
- 2332 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2333 Statement of Michael Pervan, 24 August 2022, [158].
- 2334 Statement of Kathy Baker, 18 August 2022, 29 [167].
- 2335 Statement of Mandy Clarke, 19 August 2022, 14, [46.4].
- 2336 Statement of Mandy Clarke, 19 August 2022, 14, [46.4].
- 2337 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.
- 2338 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 11.
- 2339 Email from 'Alysha' to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.
- 2340 *Children, Young Persons and Their Families Act 1997* s 14(2).
- 2341 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 2.
- 2342 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 3.
- 2343 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2344 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

- 2345 Statement of Kathy Baker, 18 August 2022, 30 [173].
- 2346 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2347 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2348 Statement of Pamela Honan, 16 November 2022, Annexure 1.14 (Minutes and actions from meeting re AYDC HR concerns, 26 October 2020) 2–3.
- 2349 Statement of Jacqueline Allen, 21 December 2022, Annexure 13 (Email from Policy & Project Officer, Child Abuse Royal Commission Response Unit to Mandy Clarke, 1 April 2021).
- 2350 Statement of Michael Pervan, 24 August 2022, [167].
- 2351 Statement of Kathy Baker, 18 August 2022, 32 [184–185]; Statement of Mandy Clarke, 19 August 2022, 14 [46.6], 15 [46.12].
- 2352 Statement of Kathy Baker, 18 August 2022, 32 [184–185].
- 2353 Transcript of Mandy Clarke, 25 August 2022, 3435 [5].
- 2354 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3441 [16–23].
- 2355 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2356 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2357 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2358 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2359 Letter from Michael Pervan to 'Lester', 9 November 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2360 Statement of Michael Pervan, 24 August 2022, [163].
- 2361 Statement of Michael Pervan, 24 August 2022, [157].
- 2362 Statement of Mandy Clarke, 19 August 2022, 13 [45].
- 2363 Statement of Mandy Clarke, 19 August 2022, 13 [45].
- 2364 Statement of Kathy Baker, 18 August 2022, 28 [163].
- 2365 Statement of Michael Pervan, 24 August 2022, [169–170].
- 2366 Statement of Kathy Baker, 18 August 2022, 33 [187].
- 2367 In a letter to the Commission, Ms Baker stated she disputes this observation; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 12.

## Case study 6: A complaint by Max (a pseudonym)

- 2368 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2369 Statement of 'Max', 19 May 2022, 1 [3].

- 2370 Statement of 'Max', 19 May 2022, 5 [23].
- 2371 Statement of 'Max', 19 May 2022, 5 [23].
- 2372 Statement of 'Max', 19 May 2022, 5 [24].
- 2373 Refer to Children, Youth and Families, 'Procedure: AYDC Significant Incident Response', undated, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2374 Statement of 'Max', 19 May 2022, 6 [26].
- 2375 Statement of 'Max', 19 May 2022, 7 [30–31].
- 2376 Statement of 'Max', 19 May 2022, 8 [36].
- 2377 Statement of 'Max', 19 May 2022, 10 [44–45].
- 2378 Statement of 'Max', 19 May 2022, 10 [44].
- 2379 Statement of 'Max', 19 May 2022, 10 [45].
- 2380 Statement of 'Max', 19 May 2022, 10 [45].
- 2381 Statement of 'Max', 19 May 2022, 10 [45]; Transcript of 'Max', 23 August 2022, 3124 [8–12].
- 2382 Statement of 'Max', 19 May 2022, 10 [46]; Transcript of 'Max', 23 August 2022, 3124 [15–17].
- 2383 Statement of 'Max', 19 May 2022, 10–11 [46].
- 2384 Transcript of 'Max', 23 August 2022, 3124 [20–27].
- 2385 Statement of 'Max', 19 May 2022, 11 [47].
- 2386 Statement of 'Max', 19 May 2022, 11 [47].
- 2387 Transcript of 'Max', 23 August 2022, 3125 [14–16].
- 2388 Statement of 'Max', 19 May 2022, 11 [47].
- 2389 Statement of 'Max', 19 May 2022, 11 [48].
- 2390 Statement of 'Max', 19 May 2022, 11 [48].
- 2391 Statement of 'Max', 19 May 2022, 11 [48].
- 2392 Statement of 'Max', 19 May 2022, 11 [49].
- 2393 Transcript of 'Max', 23 August 2022, 3125 [24–26].
- 2394 Statement of 'Max', 19 May 2022, 11 [48].
- 2395 Custodial Youth Justice Services, 'Procedure: Calling a Code', 6 February 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2396 Statement of 'Max', 19 May 2022, 11 [49].
- 2397 Statement of 'Max', 19 May 2022, 11 [49].
- 2398 Statement of 'Max', 19 May 2022, 11 [49].
- 2399 Statement of 'Max', 19 May 2022, 11 [49].
- 2400 Statement of 'Max', 19 May 2022, 11 [49–50].
- 2401 Transcript of 'Max', 23 August 2022, 3125 [34], 3126 [43].
- 2402 Letter from Leanne McLean to the Commission of Inquiry (Attachment – 'Timeline'), 23 September 2022.
- 2403 Transcript of Leanne McLean, 24 August 2022, 3321 [1–5].
- 2404 Transcript of Leanne McLean, 24 August 2022, 3322 [40–41], 3326 [36–40].
- 2405 Transcript of Leanne McLean, 24 August 2022, 3322 [34–40], 3326 [14–25].
- 2406 Transcript of Leanne McLean, 24 August 2022, 3326 [42–47], 3327 [1–3].
- 2407 Transcript of Leanne McLean, 24 August 2022, 3323 [13–26].
- 2408 Transcript of Leanne McLean, 24 August 2022, 3323 [13–26].
- 2409 Transcript of Leanne McLean, 24 August 2022, 3323 [28–30].
- 2410 Transcript of Leanne McLean, 24 August 2022, 3323 [42–47], 3324 [1–16].
- 2411 Transcript of Leanne McLean, 24 August 2022, 3328 [43–47], 3329 [1–3].
- 2412 Transcript of Leanne McLean, 24 August 2022, 3328 [45–47], 3329 [1–13].

- 2413 Transcript of Leanne McLean, 24 August 2022, 3335 [44–46].
- 2414 Transcript of Leanne McLean, 24 August 2022, 3329 [43–45].
- 2415 Transcript of Leanne McLean, 24 August 2022, 3329 [44]–3330 [6].
- 2416 Email from Leanne McLean to Pamela Honan, 15 November 2021, 2.
- 2417 Email from Leanne McLean to Pamela Honan, 15 November 2021, 1.
- 2418 Email from Leanne McLean to Pamela Honan, 15 November 2021, 1–2.
- 2419 Email from Pamela Honan to Manager, Ashley Youth Detention Centre (including forward of Leanne McLean email to Pamela Honan), 22 November 2021.
- 2420 Email from Pamela Honan to Leanne McLean, 25 November 2021.
- 2421 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 1–3.
- 2422 Transcript of Leanne McLean, 24 August 2022, 3330 [34–38].
- 2423 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2424 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2425 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2426 Manager, Ashley Youth Detention Centre, *Procedural Fairness Response*, 27 June 2023, 11.
- 2427 Manager, Ashley Youth Detention Centre, *Procedural Fairness Response*, 27 June 2023, 11.
- 2428 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2429 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2430 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2431 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2432 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2433 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2434 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2435 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2436 Ashley Youth Detention Centre, ‘List of Incidents from 1 October 2021 to 31 October 2021’, 9 November 2021; Ashley Youth Detention Centre, ‘List of Incidents from 1 November 2021 to 30 November 2021’, 13 December 2021.
- 2437 Ashley Youth Detention Centre, ‘List of Incidents from 1 October 2021 to 31 October 2021’, 9 November 2021; Ashley Youth Detention Centre, ‘List of Incidents from 1 November 2021 to 30 November 2021’, 13 December 2021.
- 2438 Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, 4 October 2021, 6, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Max]’, 6 October 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, 2 November 2021, 2; Ashley Youth Detention Centre, ‘Centre Support Team Minutes’, 8 November 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2439 Ashley Youth Detention Centre, ‘List of Incidents from 1 November 2021 to 30 November 2021’, 13 December 2021, compared to Ashley Youth Detention Centre, ‘List of Incidents from 1 October 2021 to 31 October 2021’, 9 November 2021.
- 2440 Ashley Youth Detention Centre, ‘Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Max]’, 1 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Custodial Risk Summary and Management Plan [Max]’, 1 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, ‘Custodial Risk Summary and Management Plan [Max]’, 3 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Ashley Youth Detention Centre, ‘List of Incidents from 1 November 2021 to 30 November 2021’, 13 December 2021.
- 2441 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

- 2442 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2443 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2444 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2445 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 8 November 2021.
- 2446 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2447 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2448 Transcript of Manager, Ashley Youth Detention Centre [date omitted].
- 2449 Statement of Pamela Honan, 16 November 2022, 8 [15(a)]; Email from Leanne McLean to Pamela Honan, 15 November 2021, 1.
- 2450 Statement of Pamela Honan, 16 November 2022, 8 [15(b)].
- 2451 Statement of Pamela Honan, 16 November 2022, 8 [15(b)].
- 2452 Email from Pamela Honan to Manager, Ashley Youth Detention Centre, 22 November 2021, 1.
- 2453 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2454 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2455 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 27 October 2021, 1; Ashley Youth Detention Centre, 'Custodial Risk Summary and Management Plan [Max]', 27 October 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'List of Incidents from 1 October 2021 to 31 October 2021', 9 November 2021.
- 2456 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2457 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2458 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.
- 2459 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 3.
- 2460 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 3.
- 2461 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1.
- 2462 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.
- 2463 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1.
- 2464 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.
- 2465 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1. Refer to Chapter 10 for a description of the behaviour management system.
- 2466 Request for statement served on Pamela Honan, 21 October 2022, 9 [15(b)].
- 2467 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.
- 2468 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

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- 2469 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2470 The names 'Ira', 'Lester' and 'Stan' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2471 Notice to produce served on the Tasmanian Government, 9 March 2022, 9 [22]–10 [23]; Request for statement served on Michael Pervan, 2 August 2022, 20 [60].
- 2472 Notice to produce served on the Tasmanian Government, 9 March 2022, 6 [13]; Department of Justice, 'Response to NTP-TAS-004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.



- 2473 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 21 [92]–22 [95], produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Craig Limkin, Acting Secretary, Department of Premier and Cabinet to the Commission of Inquiry, 20 July 2023.
- 2474 Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 6 [25]; Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 5 [25]; Statement of Youth Worker, Ashley Youth Detention Centre, 1 June 2022, 7 [38]; Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 8 August 2022, 27–28 [103]; Statement of former Youth Worker, Ashley Youth Detention Centre, 8 August 2022, 8 [121]; Statement of former Project Officer, Ashley Youth Detention Centre, 15 August 2022, 39 [120].
- 2475 *Royal Commission into Institutional Responses to Child Sexual Abuse: Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 11; William O'Donohue, Caroline Cummings and Brendan Willis, 'The Frequency of False Allegations of Child Sexual Abuse: A Critical Review' (2018) *Journal of Child Sexual Abuse* 27(5), 459–475; Claire Ferguson and John Malouff, 'Assessing Police Classifications of Sexual Assault Reports: A Meta-Analysis of False Reporting Rates' (2016) *Archives of Sexual Behaviour* 45, 1185–1193.
- 2476 Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 8 August 2022, 19 [62]; Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 4 [21]; Statement of Youth Worker, Ashley Youth Detention Centre, 29 May 2022, 9 [21].
- 2477 Transcript of Sarah Spencer, 18 August 2022, 2820 [2–26]; Ivan Dean, Submission No. 23 to Legislative Council Sessional Committee Government Administration B, *Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters* (March 2023) 4.
- 2478 Statement of Youth Worker, Ashley Youth Detention Centre, 29 May 2022, 14 [45]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 11 [84]; Statement of Fiona Atkins, 15 August 2022, 15 [48].
- 2479 Statement of 'Ben', 29 March 2022, 4 [19]; Statement of 'Warren', 19 May 2022, 2 [8], [11]. The names 'Ben' and 'Warren' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2480 Transcript of 'Max', 23 August 2022, 3123 [24–43]. The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, 4 [19]; Call with anonymous, 24 August 2022.
- 2481 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 64 [325–326].
- 2482 Statement of 'Alysha', 16 August 2022, 66 [335–337], [340], 68 [348–349].
- 2483 Tasmania, *Tasmanian Government Gazette*, No 21 907, 28 August 2019, 498; State of Tasmania, *Procedural Fairness Response*, 23 August 2023, 4.
- 2484 Statement of Jonathan Higgins, 7 June 2022, 2 [3].
- 2485 Ombudsman Tasmania, 'About us' (Web Page) <<https://www.ombudsman.tas.gov.au/about-us>>; Office of the Custodial Inspector, 'About us' (Web Page) <[https://www.custodialinspector.tas.gov.au/about\\_us](https://www.custodialinspector.tas.gov.au/about_us)>.
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- 2487 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], 23 [97], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2488 Statement of Peter Graham, 15 August 2022, 5, 12–13.
- 2489 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

- 2490 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations', 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Response to NTP-TAS-004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2491 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2492 *Youth Justice Act 1997* ss 3 (definition of 'guardian' para (c)), 83(3).
- 2493 *Children, Young Persons and Their Families Act 1997* s 6.
- 2494 Refer generally to *Children, Young Persons and Their Families Act 1997*, in particular Part 7, and *Youth Justice Act 1997*, in particular Part 6, Division 3.
- 2495 *Youth Justice Act 1997* s 124(1).
- 2496 Refer to *Howard v Jarvis* (1958) 98 CLR 177, 183; *Campbell v Northern Territory of Australia* [2018] FCA 85, [64] cited in Neil Morrissey, 'The Duty of Care Owed to Prisoners by Prison Authorities' (2018) 147 *Precedent* 39, 40. Refer also to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 10, 62.
- 2497 *Civil Liability Act 2002* pt 10C div 2, as inserted by the *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019* s 6.
- 2498 *Civil Liability Act 2002* pt 10C div 3, as inserted by the *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019* s 6.
- 2499 *Work Health and Safety Act 2012* s 19.
- 2500 *Criminal Code Act 1924* s 105A, as inserted by the *Criminal Code and Related Legislation Amendment (Child Abuse) Act 2019* s 7.
- 2501 *Criminal Code Act 1924* s 105A(3).
- 2502 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.
- 2503 *Registration to Work with Vulnerable People Act 2013* s 11A(1)(b).
- 2504 *Registration to Work with Vulnerable People Act 2013* ss 28, 33, 46(2), 46(5).
- 2505 Statement of Peter Graham, 15 August 2022, 3.
- 2506 Statement of Peter Graham, 15 August 2022, 3.
- 2507 Statement of Peter Graham, 15 August 2022, 2; *Registration to Work with Vulnerable People Act 2013* s 49(2).
- 2508 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 6, 92, 97, 111.
- 2509 *Registration to Work with Vulnerable People Regulations 2014* reg 5A.
- 2510 *Registration to Work with Vulnerable People Act 2013* s 3 (definition of 'reporting body').
- 2511 Statement of Peter Graham, 15 August 2022, 2. Refer also to *Registration to Work with Vulnerable People Regulations 2014* reg 4H.
- 2512 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.
- 2513 *Registration to Work with Vulnerable People Act 2013* s 53A(2).
- 2514 *Registration to Work with Vulnerable People Act 2013* s 53A, as enacted.
- 2515 Transcript of Peter Graham, 24 August 2022, 3213 [6–13].



- 2516 Transcript of Peter Graham, 24 August 2022, 3213 [32]–3214 [1].
- 2517 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.
- 2518 Statement of Jacqueline Allen, 21 December 2022, 13 [78–84]; Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Emails between Jacqueline Allen and Risk Assessment Officer, Registration to Work with Vulnerable People, 11 August 2020).
- 2519 Transcript of Peter Graham, 24 August 2022, 3216 [24–25].
- 2520 *Registration to Work with Vulnerable People Act 2013* ss 28(1A)(d), 53B(1) and *Registration to Work with Vulnerable People (Risk Assessment for Child-related Activities) Order 2014* ord 5, which refers to the information the Registrar can take into account when determining an application for registration or conducting an additional risk assessment for a person who is already registered under the Act, some of which would only be available to the Registrar if an agency had notified them of this information (prior to any duty to report, which only applies when a person is already registered): ords 2(m), 5(1)(l).
- 2521 *Personal Information Protection Act 2004* sch 1, item 2(1)(d).
- 2522 Transcript of Peter Graham, 24 August 2022, 3218 [34–39].
- 2523 Statement of Peter Graham, 15 August 2022, 9. Refer also to *Children, Young Persons and Their Families Act 1997* s 14.
- 2524 Transcript of Peter Graham, 24 August 2022, 3214 [37]–3215 [11].
- 2525 Transcript of Peter Graham, 24 August 2022, 3215 [11–16].
- 2526 Statement of Peter Graham, 15 August 2022, 9.
- 2527 Statement of Peter Graham, 15 August 2022, 5.
- 2528 Statement of Peter Graham, 15 August 2022, 4.
- 2529 Statement of Peter Graham, 15 August 2022, 4.
- 2530 Statement of Peter Graham, 15 August 2022, 4.
- 2531 Statement of Peter Graham, 15 August 2022, 4.
- 2532 Statement of Peter Graham, 15 August 2022, 4.
- 2533 *Registration to Work with Vulnerable People Act 2013* s 30(2)(b).
- 2534 Statement of Peter Graham, 15 August 2022, 4.
- 2535 Statement of Peter Graham, 15 August 2022, 6–7 (citations omitted).
- 2536 Transcript of Peter Graham, 24 August 2022, 3222 [6–8].
- 2537 Transcript of Peter Graham, 24 August 2022, 3222 [46]–3223 [7].
- 2538 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 5 [7].
- 2539 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 5 [7].
- 2540 Transcript of Peter Graham, 24 August 2022, 3222 [14–25].
- 2541 Tasmania Police, ‘Tasmanian Government’s Current Service System’, 23 August 2021, 6–7, produced by Tasmania Police in response to a Commission notice to produce; *Children, Young Persons and Their Families Act 1997* s 14; *Registration to Work with Vulnerable People Act 2013* ss 3, 53A; *Criminal Code Act 1924* s 105A.
- 2542 Statement of Jonathan Higgins, 8 August 2022, 3 [3].
- 2543 Statement of Jonathan Higgins, 8 August 2022, 3 [3], [5].
- 2544 Statement of Jonathan Higgins, 8 August 2022, 3 [3–5].
- 2545 Statement of Jonathan Higgins, 8 August 2022, 3 [6].
- 2546 Transcript of Jonathan Higgins, 24 August 2022, 3237 [25–28].
- 2547 Statement of Jonathan Higgins, 8 August 2022, 3 [3].
- 2548 Statement of Jonathan Higgins, 8 August 2022, 3 [4].
- 2549 Statement of Jonathan Higgins, 8 August 2022, 3 [3].
- 2550 Statement of Jonathan Higgins, 8 August 2022, 3 [4].

- 2551 Transcript of Jonathan Higgins, 24 August 2022, 3234 [30]–3235 [13].
- 2552 Transcript of Jonathan Higgins, 24 August 2022, 3234 [35]–3235 [18], 3237 [9–28].
- 2553 Statement of Jonathan Higgins, 8 August 2022, 5 [10].
- 2554 Statement of Jonathan Higgins, 8 August 2022, 5 [11]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-021, 2.
- 2555 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, Attachment 3 ('National Redress Scheme Operational Manual for Participating Institutions', August 2018) 42.
- 2556 Statement of Jonathan Higgins, 8 August 2022, 5 [10]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-021 (Letter from Jonathan Higgins to Commanders, Tasmania Police, 18 January 2021) 2.
- 2557 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 16.
- 2558 The Code of Conduct is in the *State Service Act 2000* s 9 ('State Service Act'). Relevant employment directions are: Tasmanian Government, *Employment Direction No. 4—Procedure for the suspension of State Service employees with or without pay* (4 February 2013); Tasmanian Government, *Employment Direction No. 5—Procedures for the investigation and determination of whether an employee has breached the Code of Conduct* (4 February 2013). Employment Direction No. 5 was updated in April 2023. Tasmanian Government, *Employment Direction No. 6 – Procedures for the investigation and determination of whether an employee is able to efficiently and effectively perform their duties* (4 February 2013). Also relevant are the State Service Principles, which are in section 7 of the *State Service Act 2000* ('State Service Principles'). The State Service Principles are a statement about the way employment in the State Service is to be managed, and the standards expected of State Service employees.
- 2559 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9–10. We note that the Integrity Commission's guide was first published in 2017 and was updated in 2021. There are some slight textual differences between these versions, but they are otherwise substantially the same and the differences are not material for the purposes of this case study.
- 2560 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.
- 2561 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 2.
- 2562 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15.
- 2563 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15.
- 2564 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15–16.
- 2565 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 16.
- 2566 Statement of Michael Pervan, 14 June 2022, 43 [226]; Transcript of Jacqueline Allen, 25 August 2022, 3370 [40]–3371 [11].
- 2567 Transcript of Jacqueline Allen, 25 August 2022, 3371 [8–11].
- 2568 Transcript of Jacqueline Allen, 25 August 2022, 3372 [16–20].
- 2569 Statement of Jacqueline Allen, 15 August 2022, 43 [247].
- 2570 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 3 [6].
- 2571 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 3 [6].
- 2572 Statement of Jacqueline Allen, 15 August 2022, 36 [200]; Statement of Kathy Baker, 18 August 2022, 33 [193]; Transcript of Kathy Baker, 25 August 2022, 3420 [14]–3421 [15].
- 2573 Statement of Kathy Baker, 18 August 2022, 15 [79]; Statement of Kathy Baker, 16 November 2022, 5 [8]; Statement of Mandy Clarke, 16 November 2022, 5 [8(a)]; Statement of Michael Pervan, 20 December 2022, 11 [39]; Transcript of Jacqueline Allen, 25 August 2022, 3370 [33–38].
- 2574 Statement of Jacqueline Allen, 15 August 2022, 47 [283].
- 2575 Statement of Jacqueline Allen, 15 August 2022, 32–33 [182].
- 2576 Statement of Mandy Clarke, 19 August 2022, 11 [39]; Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated), 2 [2.2]–3 [2.6].

- 2577 Department of Communities, 'Briefing for the Minister: Employment Matters at Ashley Youth Detention Centre (AYDC)', 4 November 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2578 Request for statement served on Michael Pervan, 2 August 2022, 7 [7], 10 [26], 14–15 [39]; Request for statement served on Mandy Clarke, 2 August 2022, 7 [7], 10 [26], 14 [39]; Request for statement served on Kathy Baker, 2 August 2022, 7 [7], 10 [26], 14–15 [39]; Request for statement served on Jacqueline Allen, 28 July 2022, 10 [26], 13–14 [47].
- 2579 Transcript of Michael Pervan, 26 August 2022, 3505 [38–47].
- 2580 Transcript of Michael Pervan, 26 August 2022, 3507 [1–10].
- 2581 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 2.
- 2582 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 1.
- 2583 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 5.
- 2584 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 1; Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 5 [14(c)].
- 2585 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report—Round 4* (Report, November 2014) 10, 14.
- 2586 Transcript of Michael Pervan, 26 August 2022, 3502 [7–17].
- 2587 Transcript of Michael Pervan, 26 August 2022, 3502 [18–33].
- 2588 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007).
- 2589 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 1.
- 2590 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 1.
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- 2593 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 2.
- 2594 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 2.
- 2595 Statement of Michael Pervan, 23 August 2022, 10 [32]; Statement of Jacqueline Allen, 21 December 2022, 15–16 [99], 17–18 [116]; Transcript of Kathy Baker, 25 August 2022, 3410 [27–35].
- 2596 Statement of Michael Pervan, 23 August 2022, 10 [32].
- 2597 Statement of Michael Pervan, 23 August 2022, 10 [32]. In relation to senior leadership generally, refer to Statement of Michael Pervan, 20 December 2022, 5 [17]; Statement of Jacqueline Allen, 21 December 2022, 7 [53].
- 2598 Transcript of Michael Pervan, 26 August 2022, 3502 [42], 3503 [8–9].
- 2599 Transcript of Michael Pervan, 26 August 2022, 3506 [34–40].
- 2600 Statement of Michael Pervan, 23 August 2022, 11 [34], 35 [130]–36 [133], 38 [142], 39 [149–151], 40 [155], 44 [170], 45 [173], 81 [340].
- 2601 Statement of Ginna Webster, 29 April 2022, 1 [6–8]; Statement of Ginna Webster, 13 January 2023, 15 [28(e)(i)].
- 2602 Statement of Pamela Honan, 16 November 2022, 2 [6]; Statement of former Director, Strategic Youth Services, Department of Communities, 28 November 2022, 35 [103].

- 2603 Statement of Jacqueline Allen, 21 December 2022, 7 [51]; Transcript of Michael Pervan, 26 August 2022, 3503 [11–21].
- 2604 Transcript of Michael Pervan, 26 August 2022, 3504 [2–18]; Statement of Jacqueline Allen, 21 December 2022, 7 [51–52]; Transcript of Kathy Baker, 25 August 2022, 3410 [28–35].
- 2605 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3410 [37]–3411 [33]; Transcript of Michael Pervan, 26 August 2022, 3505 [38]–3506 [46].
- 2606 Transcript of Michael Pervan, 26 August 2022, 3505 [43]–3506 [30].
- 2607 Statement of Michael Pervan, 23 August 2022, 10 [29], 11 [34], 35 [130]–36 [133], 39 [149–151], 40 [155], 43 [168], 44 [170], [172], 45 [173], [178], 46 [180], 47 [184], 81 [340]; Statement of Michael Pervan, 20 December 2022, 20 [77].
- 2608 Statement of Michael Pervan, 23 August 2022, 10 [29].
- 2609 Statement of Michael Pervan, 23 August 2022, 35 [132].
- 2610 Department for Education, Children and Young People, ‘Abuse in State Care Support Service’ (Web Page) <<https://www.decyp.tas.gov.au/children/adoptions-and-permanency-services/abuse-in-state-care-support-service/>>.
- 2611 Statement of Michael Pervan, 7 June 2022, 19 [118].
- 2612 Department of Communities, ‘NTP-TAS-02 – Item 15 Cover sheet’, 20 September 2021, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘AYDC Child Sexual Abuse Allegations’, 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce.
- 2613 Department of Communities, ‘AYDC Child Sexual Abuse Allegations’ (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘Response – Item 19’, 11 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2614 Department of Communities, ‘AYDC Child Sexual Abuse Allegations’, 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce.
- 2615 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2616 Department of Communities, ‘ED tracker’ (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2617 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2618 Department of Communities, ‘ED tracker’ (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2619 Department of Communities, ‘ED tracker’ (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2620 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2621 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘ED tracker’ (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2622 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2623 Department of Communities, ‘Magistrate’s Decision’, 14 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2626 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2627 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.
- 2628 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2629 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2632 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2633 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2634 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2635 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2636 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2637 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2638 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2639 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2640 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2641 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2642 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order 18 August 2022.
- 2643 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2644 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2645 The name 'Erin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.
- 2646 Statement of Jacqueline Allen, 20 August 2022, 2–3.
- 2647 Statement of Jacqueline Allen, 20 August 2022, 2–3.



- 2648 Statement of Jacqueline Allen, 20 August 2022, 5.
- 2649 Statement of Jacqueline Allen, 20 August 2022, 5.
- 2650 Statement of Jacqueline Allen, 20 August 2022, 5; *Tasmanian State Service Act 1984* s 54(1)(e) (repealed).
- 2651 Statement of Jacqueline Allen, 20 August 2022, 5.
- 2652 Statement of Jacqueline Allen, 20 August 2022, 4.
- 2653 Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2654 Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2655 Statement of Michael Pervan, 23 August 2022, 31 [112]; Transcript of Michael Pervan, 26 August 2022, 3507 [42]–3508 [13].
- 2656 Statement of Jacqueline Allen, 20 August 2022, 2.
- 2657 Statement of Jacqueline Allen, 20 August 2022, 3–4.
- 2658 Statement of Jacqueline Allen, 20 August 2022, 2; Department of Health and Human Services, 'Draft Issues Briefing for the Minister: Allegations of Sexual Assault by a Resident at Ashley Youth Detention Centre (Ashley) Against a Staff Member There', [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2659 Statement of Jacqueline Allen, 20 August 2022, 5; Ashley Youth Detention Centre, 'Memo from former Manager, Custodial Youth Justice to [Walter]: Allegations Made by Resident [redacted]', [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2660 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2661 Statement of Jacqueline Allen, 20 August 2022, 2.
- 2662 Statement of Jacqueline Allen, 20 August 2022, 3.
- 2663 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.
- 2664 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.
- 2665 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 20 August 2022, 2.
- 2666 Statement of Jacqueline Allen, 20 August 2022, 3.
- 2667 Statement of Jacqueline Allen, 20 August 2022, 4–5.
- 2668 Statement of Jacqueline Allen, 20 August 2022, 3.
- 2669 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2670 Statement of Jacqueline Allen, 20 August 2022, 4.
- 2671 Child Safety Service, 'Notification Report', [date omitted], 4–5, 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2672 Child Safety Service, 'Notification Report', [date omitted], 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2673 Notice to produce served on the Tasmanian Government, 9 March 2022, 11–12 [19]; Request for statement served on Jacqueline Allen, 28 July 2022, 13–14 [47]; Statement of Jacqueline Allen, 20 August 2022.
- 2674 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 22.

- 2675 Statement of Peter Graham, 15 August 2022, Attachment H (Letter from Peter Graham to ‘Walter’, 27 July 2021) 6.
- 2676 Statement of ‘Erin’, 18 July 2022, 2 [13], 4 [20], 7[36]; File note of telephone conversation from the Commission of Inquiry to ‘Erin’, 18 July 2023.
- 2677 Transcript of ‘Erin’, 22 August 2022, 3021 [3–6].
- 2678 Transcript of ‘Erin’, 22 August 2022, 3021 [6–10]; Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2679 Transcript of ‘Erin’, 22 August 2022, 3021 [10–16]; Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2680 Transcript of ‘Erin’, 22 August 2022, 3021 [18–24].
- 2681 Transcript of ‘Erin’, 22 August 2022, 3029; Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [dated omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2682 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.
- 2683 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2684 Statement of ‘Erin’, 18 July 2022, Attachment [Erin]–001 (‘Letter from Investigation Officer, Ombudsman Tasmania, to ‘Erin’, [date omitted]).
- 2685 Statement of ‘Erin’, 18 July 2022, Attachment [Erin]–001 (‘Letter from Investigation Officer, Ombudsman Tasmania, to ‘Erin’, [date omitted]).
- 2686 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2687 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2688 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2689 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2690 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2691 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2692 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2693 Memo from Manager Custodial Youth Justice to ‘Walter’, ‘Complaint to Ombudsman from [Erin]’, [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.
- 2694 Submission 159 Ombudsman Tasmania, 2.
- 2695 Submission 159 Ombudsman Tasmania, 2.
- 2696 Statement of ‘Erin’, 18 July 2022, 3 [17].
- 2697 Statement of ‘Erin’, 18 July 2022, 3 [18].
- 2698 Statement of ‘Erin’, 18 July 2022, 3 [18].
- 2699 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.
- 2700 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.
- 2701 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.



- 2702 Transcript of Richard Connock, 24 August 2022, 3314 [22–25], 3315 [1–3].
- 2703 Submission 159 Ombudsman Tasmania, 1.
- 2704 Submission 159 Ombudsman Tasmania, 1–2.
- 2705 Richard Connock, *Procedural Fairness Response*, 31 May 2023, 2.
- 2706 Department of Communities, ‘File 58: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre’, [date omitted] 2009, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘File 99: Documents relating to complaints made by a young person detained in Ashley Youth Detention Centre’, [date omitted] 2010, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘File 164: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre’, [date omitted] 2013, 1, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2707 Department of Communities, ‘File 99: Documents relating to complaints made by a young person detained in Ashley Youth Detention Centre’, [date omitted] 2010, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘File 58: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre’, [date omitted] 2009, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2708 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2709 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2710 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 8, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2711 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 1, 2, 4, produced by the Tasmanian Government in response to a Commission notice to produce; James Cumming Investigation Services, ‘Employment Direction No. 5 Investigation’, [date omitted], 60–61, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2712 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2713 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2714 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2715 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2716 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 3, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2717 Department of Communities, ‘Allegations and incidents – Stand downs’ (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

- 2718 Email from Assistant Consultant, Safety and Injury Management to Fiona Atkins, 27 April 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 22–23; Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 2.
- 2719 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2720 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2721 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2722 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2723 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]’, [date omitted], 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2724 James Cumming Investigation Services, ‘Employment Direction No. 5 Investigation Report regarding [Walter]’, [date omitted], 52–53, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2725 James Cumming Investigation Services, ‘Employment Direction No. 5 Investigation Report regarding [Walter]’, [date omitted], 53, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2726 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Employment Direction No. 5 Investigation Report – [Walter]’, [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.
- 2727 Department of Health and Human Services, ‘Minute to Acting Deputy Secretary Children: Employment Direction No. 5 Investigation Report – [Walter]’, [redacted], 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2728 Statement of Michael Pervan, 23 August 2022, 32 [117].
- 2729 Deed of Release between ‘Walter’ and the State of Tasmania, [date omitted], 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2730 Deed of Release between ‘Walter’ and the State of Tasmania, [date omitted], 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2731 Transcript of Michael Pervan, 26 August 2022, 3510 [32]–3511 [18].
- 2732 Statement of Michael Pervan, 23 August 2022, 31 [113].
- 2733 *Evidence Act 2001 s 97A*.
- 2734 Transcript of Michael Pervan, 26 August 2022, 3510 [32–38].
- 2735 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 14.
- 2736 Statement of Ginna Webster, 10 June 2022, 51 [325].
- 2737 Statement of Ginna Webster, 10 June 2022, 50 [321(b)–(c)].
- 2738 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 3.
- 2739 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.
- 2740 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.
- 2741 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.
- 2742 Statement of Ginna Webster, 10 June 2022, 3 [17], 5 [27].

- 2743 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 3.
- 2744 Refer, for example, to Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 6 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 26 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 5 October 2020, 1.
- 2745 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.
- 2746 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 9-10; Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', Strategy and Engagement Division, 7 October 2019) 1.
- 2747 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.
- 2748 Statement of Michael Pervan, 7 June 2022, 18–19 [116].
- 2749 Statement of Michael Pervan, 7 June 2022, 18 [114]; Statement of Ginna Webster, 10 June 2022, 51 [326].
- 2750 Statement of Michael Pervan, 7 June 2022, 18 [114].
- 2751 Statement of Ginna Webster, 10 June 2022, 51 [327].
- 2752 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2753 The numbers are slightly different to those in Case study 1 as we are referring here to allegations against staff only.
- 2754 Statement of Kathy Baker, 18 August 2022, 11 [36].
- 2755 Notice to produce served on the State of Tasmania, 9 March 2022, 10 [18]; Request for statement served on Darren Hine, 29 July 2022, 5 [1]; Request for statement served on Peter Graham, 1 August 2022, 4 [1]–6 [5]; Request for statement served on Michael Pervan, 2 August 2022, 13 [35]; Request for statement served on Kathy Baker, 2 August 2022, 13 [35]; Request for statement served on Mandy Clarke, 2 August 2022, 13 [35]. We also made requests to Centre management and other departmental witnesses on this point and made further requests for this information following our hearings.
- 2756 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 7, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2757 The name 'Parker' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.
- 2758 Department of Communities, 'Notification regarding [Parker]', 9 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2759 The name 'Baxter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Department of Communities, 'Notification regarding [Baxter]', 18 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2760 Department of Communities, 'Notification regarding [Baxter]', 18 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4–5, Attachment 1.
- 2761 Statement of Jacqueline Allen, 21 December 2022, Attachment 6.1 (Child Abuse Review Team file: [Parker], March 2010) 24, 29; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4, Attachment 1.
- 2762 Statement of Jacqueline Allen, 21 December 2022, Attachment 6.1 (Child Abuse Review Team file: [Parker], March 2010) 25; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4.

- 2763 Statement of Pamela Honan, 16 November 2022, 4 [9(a)]; Statement of Kathy Baker, 18 August 2022, 34 [198]; Statement of Jacqueline Allen, 21 December 2022, 6 [45]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2764 Statement of Stuart Watson, 16 August 2022 (revised 23 August 2022), 4–5 [21].
- 2765 Department of Communities, 'Details relating to [Ira's] restricted duties', 27 May 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2766 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1.
- 2767 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1.
- 2768 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1–2.
- 2769 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 2.
- 2770 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 2.
- 2771 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019).
- 2772 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 5–6.
- 2773 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 1, 6.
- 2774 Email from Assistant Director, Safety, Wellbeing and Industrial Relations to Director, Office of the Secretary, 18 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2775 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce. Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)].
- 2776 Statement of Michael Pervan, 23 August 2022, 48 [188]; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2777 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2778 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2779 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3; Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2780 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.
- 2781 Statement of Jacqueline Allen, 21 December 2022, 3 [20–21].

- 2782 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 90.19 (Email from Jacqueline Allen to Jonathan Higgins, 21 October 2020).
- 2783 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2784 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2785 Statement of Kathy Baker, 18 August 2022, 24 [135].
- 2786 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2787 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of *The Nurse* podcast, 2 November 2020, 56.
- 2788 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2789 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2790 Kathy Baker and Mandy Clarke, *Procedural Fairness Response*, 26 July 2023, 3; Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(b)].
- 2791 Statement of Jacqueline Allen, 21 December 2022, Attachment 57 (AYDC Working Group, Minutes, 12 February 2021) 1–2; Statement of Jacqueline Allen, 21 December 2022, Attachment 59 (Strengthening Safeguards Executive Working Group, Minutes, 19 March 2021) 2.
- 2792 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2793 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2794 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 34–35.
- 2795 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 35.
- 2796 Statement of Peter Graham, 15 August 2022, 5.
- 2797 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 37.
- 2798 Email from Assistant Director, Safety, Wellbeing and Industrial Relations to Director, Office of the Secretary, 18 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Secretary Michael Pervan to Deputy Commissioner, Tasmania Police, 18 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce.



- 2799 Request for statement served on Tasmania Police, 29 July 2022, 5 [1]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2800 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 90.19 (Email from Jacqueline Allen to Jonathan Higgins, 21 October 2020).
- 2801 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-002 ('Reference material – additional information – [Stan]') 3–17.
- 2802 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 33–37; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2803 Request for statement served on Tasmania Police, 29 July 2022, 5 [1]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 33–37; Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2804 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2805 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 10, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2806 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 44.
- 2807 Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.
- 2808 Tasmania Police Child Abuse Review Team, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police Child Abuse Review Team, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.
- 2809 Tasmania Police, 'Disclosure Report – Intel Submission ([Lester])', [date omitted], produced by Tasmania Police in response to a Commission notice to produce.
- 2810 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2811 Statement of Jonathan Higgins, 7 November 2022, 22 [58]; Statement of Michael Pervan, 23 August 2022, 38 [145]; Statement of Kathy Baker, 18 August 2022, 28 [157].
- 2812 Department for Education, Children and Young People, 'AYDC (01 Jan 2000 – 20 July 2021) Sexual Abuse Claims' (Spreadsheet), 11 October 2021, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

- 2813 Statement of former Director of Strategy, Program Development and Evaluation, Department of Communities, 26 August 2022, 19 [81–84]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2814 Statement of Michael Pervan, 23 August 2022, 39 [148]; Statement of former Director of Strategy, Program Development and Evaluation, Department of Communities, 26 August 2022, 20 [89]. Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2815 Statement of ‘Alysha’, 16 August 2022, 64 [326]; Statement of Stuart Watson, 11 November 2022, Attachment 3 (Email from ‘Alysha’ to Pamela Honan, 9 January 2020); Email from ‘Alysha’ to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.
- 2816 Statement of ‘Alysha’, 16 August 2022, 66 [335–336]; Transcript of ‘Alysha’, 22 August 2022, 3071 [43–47]; Email from ‘Alysha’ to Pamela Honan et al, 9 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2817 Department of Communities, ‘Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan’, 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2818 Tasmania Police, ‘Disclosure Report – Intel Submission ([Lester])’, 10 September 2020, 1, produced by Tasmania Police in response to a Commission notice to produce.
- 2819 Tasmania Police, ‘Disclosure Report – Intel Submission ([Lester])’, 10 September 2020, 1, produced by Tasmania Police in response to a Commission notice to produce.
- 2820 Statement of Kathy Baker, 18 August 2022, 23–24 [131]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.
- 2821 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1.
- 2822 Statement of Michael Pervan, 6 September 2022, 1 [4]; Department of Communities, ‘ED tracker’ (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, ‘Employment Histories – AYDC’, 29 March 2022, 10, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2823 Statement of Michael Pervan, 6 September 2022, 1 [3–4]; Statement of Michael Pervan, 6 October 2022, 1 [2]; Transcript of Michael Pervan, 26 August 2022, 3498 [10–32]; Statement of Pamela Honan, 16 November 2022, 4 [9(a)].
- 2824 Statement of ‘Alysha’, 16 August 2022, 67 [346]; Statement of Pamela Honan, 18 August 2022, 36 [59.7]; Pamela Honan, *Procedural Fairness Response*, 25 July 2023.
- 2825 Transcript of Stuart Watson, 23 August 2022, 3186 [33–44].
- 2826 Transcript of Pamela Honan, 19 August 2022, 2976 [45–47].
- 2827 Statement of Kathy Baker, 18 August 2022, 26 [150].
- 2828 Kathy Baker and Mandy Clarke, *Procedural Fairness Response*, 26 July 2023, 8.
- 2829 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.
- 2830 Letter from Lawyer to Leanne McLean, 26 August 2020, 1.
- 2831 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1.
- 2832 Transcript of Mandy Clarke, 25 August 2020, 3408 [30–46].
- 2833 Email from Director, Child Abuse Royal Commission Response Unit to Mandy Clarke, 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, ‘Claims of Abuse in AYDC’ (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2834 Statement of Kathy Baker, 18 August 2022, 26 [150].
- 2835 Statement of Kathy Baker, 18 August 2022, 24 [135].
- 2836 Email from Jacqueline Allen to Jonathan Higgins, 6 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Statement of Michael Pervan, 23 August 2022, 42 [160].



- 2837 Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.
- 2838 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2839 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2840 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2841 Letter from Michael Pervan to 'Lester', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2842 Statement of Michael Pervan, 6 September 2022, 1 [3–4]; Statement of Michael Pervan, 6 October 2022, 1 [2]; Statement of Pamela Honan, 16 November 2022, 4 [9(a)].
- 2843 Statement of Jacqueline Allen, 21 December 2022, Attachment 59 (Strengthening Safeguards Executive Working Group, Minutes, Department of Communities, 19 March 2021) 2.
- 2844 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2845 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-011 ('Reference material – additional information – [Lester]') 46.
- 2846 Statement of Jacqueline Allen, 21 December 2022, 4 [27]; Department of Communities, 'ED tracker' (Excel spreadsheet), 17 August 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Michael Pervan, 23 August 2022, 33 [125].
- 2847 Statement of Michael Pervan, 23 August 2022, 33 [125].
- 2848 Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2849 Transcript of Jonathan Higgins, 24 August 2022, 3250 [27–34].
- 2850 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 44.
- 2851 Statement of Peter Graham, 15 August 2022, 5.
- 2852 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 42, 45.
- 2853 The name 'Stan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 7, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2854 Department of Communities, 'Abuse of Children in State Care Assessment Process: Assessment Report', [date omitted], 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2855 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001, 4.

- 2856 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH–001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2857 Email from Jacqueline Allen to Mandy Clarke et al, 23 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2858 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 8; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.
- 2859 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 90.19 (Email from Jacqueline Allen to Jonathan Higgins, 21 October 2020).
- 2860 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2861 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 10.
- 2862 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2863 Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].
- 2864 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2865 Statement of Michael Pervan, 23 August 2022, 48 [188].
- 2866 Department of Communities, 'Notification regarding [redacted]', 15 September 2020, 1.
- 2867 Department of Communities, 'Notification regarding [redacted]', 15 September 2020, 2–3.
- 2868 Department of Communities, 'Abuse in State Care Support Service Application Report', [date omitted] 2017, 1–3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2869 Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)]; Statement of Jacqueline Allen, 21 December 2022, Attachment 88 (Email from Jacqueline Allen to Jonathan Higgins, 7 October 2020); Department of Communities, 'ED tracker' (Excel spreadsheet), 17 August 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2870 Statement of Jacqueline Allen, 21 December 2022, Attachment 90.20 (Email from Tasmania Police Detective Inspector to Jacqueline Allen, 3 November 2020); Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2871 Letter from Michael Pervan to 'Stan', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

- 2872 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2873 Letter from Michael Pervan to 'Stan', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2874 Statement of Pamela Honan, 16 November 2022, 4 [9(a)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2875 Statement of Jacqueline Allen, 21 December 2022, Attachment 80 ('Concerns regarding [Stan] and [Lester]', File note, 26 October 2020).
- 2876 Department of Communities, 'Instrument of Appointment – Investigation pursuant to Employment Direction No. 5', 12 February 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2877 Letter from Michael Pervan to 'Stan', 12 February 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2878 Email from Jacqueline Allen to Conduct and Performance Consultant, Department of Communities, 18 October 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 61–64 [339(c)].
- 2879 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2880 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (List of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].
- 2881 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Transcript of Jonathan Higgins, 24 August 2022, 3235 [23–41], 3236 [37]–3237 [2].
- 2882 Transcript of Jonathan Higgins, 24 August 2022, 3237 [4–7].
- 2883 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).
- 2884 Statement of Jacqueline Allen, 21 December 2022, Attachment 88 (Email from Jacqueline Allen to Jonathan Higgins, 7 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.
- 2885 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9.
- 2886 Statement of Peter Graham, 15 August 2022, 5.
- 2887 Statement of Peter Graham, 15 August 2022, Attachment A (Letter from Peter Graham to 'Stan', 15 April 2021); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9.
- 2888 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9–12; Statement of Peter Graham, 15 August 2022, Attachment B (Letter from Peter Graham to 'Stan', 25 February 2022) 1–2.
- 2889 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration – Reasons for Decision', 25 February 2022) 17.
- 2890 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration – Reasons for Decision', 25 February 2022) 17–18.
- 2891 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 12; Statement of Peter Graham, 15 August 2022, Attachment D ('Continuation of Positive Registration – Reasons for Decision', 7 July 2022), 1.

- 2892 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration Reasons for Decision', 25 February 2022), 17–18; Statement of Peter Graham, 15 August 2022, Attachment D (Reasons for continuation of positive registration under the *Registration to Work with Vulnerable People Act 2013* in relation to 'Stan', 7 July 2022) 3.
- 2893 Statement of Peter Graham, 15 August 2022, Attachment D (Reasons for continuation of positive registration under the *Registration to Work with Vulnerable People Act 2013* in relation to 'Stan', 7 July 2022) 5.
- 2894 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2895 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)].
- 2896 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 34.
- 2897 Statement of 'Alysha', 16 August 2022, 66 [335–336]; Email from 'Alysha' to Pamela Honan et al, 9 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)].
- 2898 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, 24 June 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Kathy Baker, 18 August 2022, 22 [120]; Statement of Kathy Baker, 18 August 2022, 33 [192].
- 2899 Transcript of Kathy Baker, 25 August 2022, 3421 [10–15]; Statement of Jacqueline Allen, 15 August 2022, 40 [214].
- 2900 Statement of 'Ben', 29 March 2022, 10 [46].
- 2901 Statement of Kathy Baker, 18 August 2022, 9 [30], 34 [194]; Transcript of Kathy Baker, 25 August 2022, 3406 [8–16], 3421 [4–15]; Transcript of Stuart Watson, 23 August 2022, 3187 [40–47]; Transcript of Jacqueline Allen, 25 August 2022, 3366 [23–27].
- 2902 Transcript of Stuart Watson, 23 August 2022, 3187 [47]–3188 [4]; Statement of Pamela Honan, 18 August 2022, 54 [84.2].
- 2903 Statement of Kathy Baker, 18 August 2022, 33 [193].
- 2904 Statement of Kathy Baker, 18 August 2022, 9 [30], 34 [194]; Transcript of Kathy Baker, 25 August 2022, 3406 [8–16], 3421 [4–16].
- 2905 Statement of Kathy Baker, 18 August 2022, 33 [193]–34 [194].
- 2906 Transcript of Kathy Baker, 25 August 2022, 3421 [10–15].
- 2907 Transcript of Kathy Baker, 25 August 2022, 3406 [8–16].
- 2908 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2909 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2910 Statement of Stuart Watson, 16 August 2022 (revised 23 August 2022), 3–4 [21].
- 2911 Transcript of Patrick Ryan, 7 September 2022, 3590 [10–12].
- 2912 Transcript of Patrick Ryan, 7 September 2022, 3590 [35–36].
- 2913 Transcript of Patrick Ryan, 7 September 2022, 3588 [45]–3689 [36].
- 2914 Transcript of Patrick Ryan, 7 September 2022, 3590 [17–21].
- 2915 Statement of Michael Pervan, 23 August 2022, 45 [173]; Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 1–2; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

- 2916 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].
- 2917 Transcript of Jonathan Higgins, 24 August 2022, 3244 [13–21].
- 2918 Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020) 1–4; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2919 Statement of Kathy Baker, 18 August 2022, 9 [29].
- 2920 Statement of Mandy Clarke, 19 August 2022, 5–6 [6].
- 2921 Statement of Michael Pervan, 23 August 2022, 12 [42].
- 2922 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.
- 2923 Statement of Michael Pervan, 14 June 2022, 68 [372].
- 2924 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce. Some of these claims related to employees and others to contractors working at the Centre.
- 2925 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce. The numbers are slightly different to those in Case Study 1 as we are referring here to allegations against staff only.
- 2926 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 2927 'COVID-19 Public Health Emergency of International Concern (PHEIC) Global Research and Innovation Forum', *World Health Organization* (Web Page, 12 February 2020) <[https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-\(pheic\)-global-research-and-innovation-forum](https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-(pheic)-global-research-and-innovation-forum)>.
- 2928 Peter Gutwein, 'Ministerial Statement COVID-19 Response Measures' (Media Release, 17 March 2020) <[https://www.premier.tas.gov.au/releases/ministerial\\_statement\\_covid-19\\_response\\_measures](https://www.premier.tas.gov.au/releases/ministerial_statement_covid-19_response_measures)>.
- 2929 Statement of Kathy Baker, 16 November 2022, 3 [6]; Statement of Mandy Clarke, 16 November 2022, 3 [6(a)].
- 2930 Statement of Mandy Clarke, 16 November 2022, 4 [7(g), (h)]; Transcript of Kathy Baker, 25 August 2022, 3442 [21–32].
- 2931 Statement of Kathy Baker, 16 November 2022, 3–4 [6]; Statement of Pamela Honan, 16 November 2022, 3 [7(ii)].
- 2932 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.4 ('Meeting re AYDC HR concerns', Minutes (amended), Strengthening Safeguards Working Group, 26 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020).
- 2933 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 1.
- 2934 Statement of Pamela Honan, 16 November 2022, 3 [7(i)].
- 2935 Statement of Mandy Clarke, 19 August 2022, 13 [39.11]; Transcript of Kathy Baker, 25 August 2022, 3442 [18–32].
- 2936 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020).
- 2937 Transcript of Kathy Baker, 25 August 2022, 3442 [18–32].
- 2938 Statement of Mandy Clarke, 16 November 2022, 6 [10(b)(iii)]; Statement of Kathy Baker, 16 November 2022, 5 [7].
- 2939 Statement of Pamela Honan, 16 November 2022, 5 [10(a)–(b)].
- 2940 Statement of Mandy Clarke, 16 November 2022, 6 [10(a)].



- 2941 Statement of Mandy Clarke, 16 November 2022, 6 [10(a)].
- 2942 Statement of Michael Pervan, 20 December 2022, 7 [26].
- 2943 Statement of Jacqueline Allen, 21 December 2022, 9–10 [66].
- 2944 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2, 4; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 1.
- 2945 Statement of Pamela Honan, 16 November 2022, Attachment 1 (Email from Client Liaison Officer, Department of Communities to Pamela Honan, 27 September 2022); Statement of Jacqueline Allen, 21 December 2022, Attachment 80 ('Concerns regarding [Stan] and [Lester]', File note, 26 October 2020).
- 2946 Statement of Jacqueline Allen, 21 December 2022, Attachment 77 (Minutes from redress meeting, File note, 18 September 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2.
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- 2952 Email from Department of Communities staff member to Jacqueline Allen, 24 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2954 Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated) 2–3 [2.2–2.5]; Statement of Jacqueline Allen, 15 August 2022, 40 [211(f)].
- 2955 Transcript of Mandy Clarke, 25 August 2022, 3408 [15–22].
- 2956 Statement of Mandy Clarke, 19 August 2022, 10–11 [36]; Statement of Mandy Clarke, 19 August 2022, Annexure MC.004 (Meeting with Lawyer, Angela Sdrinis Legal, Draft Minutes, 31 August 2020) 1–2; Transcript of Mandy Clarke, 25 August 2022, 3408 [30–35].

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- 2961 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 6–7 [19].
- 2962 Transcript of Jacqueline Allen, 25 August 2022, 3378 [10–13].
- 2963 Transcript of Jacqueline Allen, 25 August 2022, 3378 [24–37].
- 2964 Statement of Mandy Clarke, 19 August 2022, 9 [27].
- 2965 Statement of Mandy Clarke, 19 August 2022, 9 [27]; Statement of Mandy Clarke, 16 November 2022, 2 [5(a)]; Transcript of Mandy Clarke, 25 August 2022, 3408 [46]–3409 [7].
- 2966 Statement of Michael Pervan, 23 August 2022, 29 [106]; Statement of Kathy Baker, 18 August 2022, 21 [115].
- 2967 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2975 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 10 [36], produced by the Tasmanian Government in response to a Commission notice to produce.
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- 2979 Statement of Jacqueline Allen, 21 December 2022, 13 [78].
- 2980 Statement of Mandy Clarke, 16 November 2022, 6 [11(a)–(c)]; Statement of Kathy Baker, 16 November 2022, 6 [11]; Statement of Pamela Honan, 16 November 2022, 8 [16]; Statement of Michael Pervan, 20 December 2022, 13 [47].
- 2981 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 35.
- 2982 Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Email from Jacqueline Allen to Risk Assessment Officer, Registration to Work with Vulnerable People, 11 August 2020) 2–3.
- 2983 Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Email from Risk Assessment Officer, Registration to Work with Vulnerable People to Jacqueline Allen, 11 August 2020).
- 2984 Statement of Jacqueline Allen, 21 December 2022, 13 [84].
- 2985 Statement of Jonathan Higgins, 7 November 2022, 2 [2].
- 2986 Statement of Jonathan Higgins, 7 November 2022, 2 [2].
- 2987 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2.
- 2988 Statement of Jacqueline Allen, 21 December 2022, 13 [82], [84].
- 2989 Statement of Jacqueline Allen, 21 December 2022, 14 [87].
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- 2991 Statement of Jonathan Higgins, 8 August 2022, 6 [13]; Statement of Jacqueline Allen, 21 December 2022, 14 [87].
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- 2993 Statement of Michael Pervan, 14 June 2022, 56 [306]; Statement of Michael Pervan, 7 June 2022, 17 [109].
- 2994 Statement of Michael Pervan, 14 June 2022, 56 [306]; Statement of Michael Pervan, 7 June 2022, 17 [109].
- 2995 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-002 ('Reference material – additional information – [Stan]') 55–62.
- 2996 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 1.
- 2997 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 3; Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated); Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
- 2998 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 3.
- 2999 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
- 3000 Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated); Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
- 3001 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
- 3002 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
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- 3004 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
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- 3009 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).
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- 3011 Transcript of *The Nurse* podcast, 2 November 2020, 56.
- 3012 Transcript of *The Nurse* podcast, 2 November 2020, 56.
- 3013 David Killick, 'Analysis: Culture of cover-up a cancer on Tasmania's democracy', *Mercury* (online, first published 20 November 2020) <<https://www.themercury.com.au/news/tasmania/analysis-culture-of-coverup-a-cancer-on-tasmanias-democracy/news-story/d12f9021cb14a67add8a875010180fe7>>.
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- 3016 Statement of Michael Pervan, 6 September 2022, Annexure MP.SUPP.001 ('Correction to Response to Question on Notice', Minute to the Secretary, 9 December 2020) 1.
- 3017 Statement of Michael Pervan, 6 September 2022, Annexure MP.SUPP.001 ('Correction to Response to Question on Notice', Minute to the Secretary, 9 December 2020).
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- 3020 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3021 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

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- 3024 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3025 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 3028 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3029 Email from Michael Pervan to Director of People and Culture et al, 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3030 Email from Michael Pervan to Director of People and Culture et al, 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3031 Statement of Michael Pervan, 23 August 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser, Mandy Clarke and Kathy Baker, 14 December 2020).
- 3032 Statement of Michael Pervan, 23 August 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser, Mandy Clarke and Kathy Baker, 14 December 2020); Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 5; Statement of Michael Pervan, 23 August 2022, 35 [130].
- 3033 Statement of Michael Pervan, 6 September 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser Mandy Clarke and Kathy Baker, 14 December 2020).
- 3034 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(d)].
- 3035 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(e)].
- 3036 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(e)].
- 3037 Statement of Michael Pervan, 20 December 2022, 20–21 [78]; Statement of Jacqueline Allen, 21 December 2022, 7 [52].
- 3038 Statement of Michael Pervan, 23 August 2022, 35 [130].

- 3039 Statement of Jacqueline Allen, 21 December 2022, 7 [52].
- 3040 Statement of Jacqueline Allen, 21 December 2022, 7 [53].
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- 3042 State of Tasmania, *Procedural Fairness Response*, 23 August 2023, 7–8.
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- 3044 Email from Michael Pervan to former Solicitor-General, 24 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
- 3045 Request for statement served on Michael Pervan, 2 August 2022, 13 [37(a)].
- 3046 Statement of Michael Pervan, 23 August 2022, 35 [130].
- 3047 Statement of Kathy Baker, 18 August 2022, 30 [172].
- 3048 Statement of Michael Pervan, 20 December 2022, 4–5 [17].
- 3049 Statement of Michael Pervan, 20 December 2022, 4 [16].
- 3050 Statement of Michael Pervan, 20 December 2022, 5 [17].
- 3051 Statement of Ginna Webster, 13 January 2023, 15–16 [28(e)].
- 3052 Statement of Jacqueline Allen, 21 December 2022, 8 [55]; Email from Michael Pervan to former Solicitor-General, 24 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 3058 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter of Advice from Assistant Solicitor-General to Michael Pervan, 15 December 2020) 3–4 [14]; Refer to *National Redress Scheme for Institutional Child Sexual Abuse Act 2018 s 97*.
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- 3061 Statement of Kathy Baker, 18 August 2022, 11 [35–38]; Statement of Michael Pervan, 23 August 2022, 47 [183].
- 3062 Statement of Jacqueline Allen, 15 August 2022, 45 [258]; Transcript of Stuart Watson, 23 August 2022, 3160 [14–23].
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- 3068 Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.
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- 3070 Transcript of Jonathan Higgins, 24 August 2022, 3250 [21–25].
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- 3076 Transcript of Jonathan Higgins, 24 August 2022, 3237 [4–7].
- 3077 Statement of Jonathan Higgins, 23 August 2022, 3–4 [9].
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- 3082 Statement of Jonathan Higgins, 23 August 2022, 8 [16]; Transcript of Jonathan Higgins, 24 August 2022, 3251 [17–43].
- 3083 Transcript of Jonathan Higgins, 24 August 2022, 3237 [14]–3238 [4].
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- 3085 Transcript of Jonathan Higgins, 24 August 2022, 3241 [5–31].
- 3086 Transcript of Jonathan Higgins, 24 August 2022, 3240 [40]–3241 [3].
- 3087 Consultation with Launceston Police, 19 August 2021.
- 3088 Consultation with Launceston Police, 19 August 2021.
- 3089 Statement of ‘Warren’, 19 May 2022, 3 [16]; Statement of ‘Max’, 19 May 2022, 6 [27]; Statement of ‘Simon’, 7 July 2022, 3 [14].
- 3090 Statement of Jacqueline Allen, 21 December 2022, 14 [91(a)].
- 3091 Transcript of Jonathan Higgins, 24 August 2022, 3258 [10–13].
- 3092 Transcript of Jonathan Higgins, 24 August 2022, 3258 [14–22].
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- 3094 Transcript of Jonathan Higgins, 24 August 2022, 3259 [2–19].
- 3095 Consultation with Launceston Police, 19 August 2021.
- 3096 Consultation with Launceston Police, 19 August 2021.
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- 3101 Statement of Peter Graham, 15 August 2022, 8.
- 3102 Statement of Peter Graham, 15 August 2022, 8.
- 3103 Statement of Peter Graham, 15 August 2022, 5.
- 3104 Transcript of Peter Graham, 24 August 2022, 3227 [34–42].
- 3105 Statement of Peter Graham, 15 August 2022, 6.
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- 3107 Statement of Peter Graham, 15 August 2022, 6; Transcript of Peter Graham, 24 August 2022, 3225 [41]–3226 [2].
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Commission of Inquiry into  
the Tasmanian Government's  
Responses to Child Sexual  
Abuse in Institutional Settings

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

Volume 5: Children in youth detention  
Book 3

August 2023



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

**Volume 5**  
**Children in youth detention (Book 3)**

**The Honourable Marcia Neave AO**

President and Commissioner

**Professor Leah Bromfield**

Commissioner

**The Honourable Robert Benjamin AM SC**

Commissioner

August 2023

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# 12 The way forward: Children in youth detention

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## 1 Introduction

In this chapter, we make recommendations aimed at preventing child sexual abuse in youth detention and improving responses to such abuse when it occurs. Throughout this chapter, we draw on the seven case studies in Chapter 11, which paint a profoundly disturbing picture of youth detention in Tasmania over the past two decades—an institution where some children and young people experienced systematic harm and abuse. The case studies also highlight longstanding and entrenched problems with culture, leadership, staffing, policies and practices in the youth detention system. The Tasmanian Government has been aware of many of these problems for some time.

### 1.1 Our recommendations

Our recommendations in this chapter are informed by several principles, including the following:

- The most effective way to protect children and young people against the risk of sexual abuse in youth detention is to prevent them entering or re-entering detention—this should be achieved by prioritising strategies that divert children and young people from the youth justice system and from detention.



- To minimise risks to Aboriginal children and young people in detention, their substantial over-representation in detention and in the broader youth justice system must be urgently addressed through strategies underpinned by Aboriginal self-determination.
- Children and young people must be safe in youth detention. The risk of child sexual abuse in youth detention decreases when there is a child safe culture in detention that respects and promotes the rights of children and young people, and for which leadership is accountable.
- For children and young people to be safe in youth detention, staff must also be safe and their wellbeing supported. Staff must have the qualifications, attributes and skills to engage constructively with children and young people in detention. There must be enough staff to deliver a therapeutic model of care to children and young people and avoid lockdowns.
- If a child or young person experiences child sexual abuse in detention, they should feel able to speak up and know they will be listened to. Their complaints must be taken seriously and acted upon without them suffering any reprisal.

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

We outline our recommendations below. Several of these recommendations will appear familiar from previous reviews of Ashley Youth Detention Centre and the youth justice system (discussed in Chapter 10). Too often these recommendations have been overlooked or implemented without achieving meaningful or enduring change. At other times they have been implemented through short-term initiatives that have later been discontinued.

System reform is urgently needed. We acknowledge that transforming a youth detention system that has been resistant to change over many years is not straightforward. It requires radical cultural change, strong leadership and a long-term commitment from the Government. It may take time, but we consider it is achievable.

Our recommendations include:

- closing Ashley Youth Detention Centre as soon as possible and creating a memorial to victim-survivors who experienced abuse at the Centre
- strengthening leadership in the youth detention system and improving governance arrangements for youth detention

- developing a participation and empowerment strategy for children in youth detention that includes establishing a new advisory group of children, young people and young adults with previous experience of detention
- ensuring staff in youth detention are appropriately qualified, trained and supported to deliver a therapeutic model of care to children in detention, with enough staff to keep children and staff safe
- increasing the minimum age of criminal responsibility to 14 years and working towards increasing the minimum age of detention to 16 years
- increasing opportunities for diversion and bail, and reducing the number of children and young people on remand
- ensuring a collaborative, multidisciplinary approach to meeting the complex needs of children and young people in detention, and providing access to high-quality mental health services and education
- establishing an integrated service for children and young people leaving detention to ensure they have safe and stable accommodation, access to physical and mental health support, and help with accessing education and/or employment after their release
- working with Aboriginal communities to develop an Aboriginal youth justice strategy, co-design new youth justice facilities and ensure Ashley Youth Detention Centre and any replacement facilities are culturally safe for Aboriginal children and young people
- establishing a policy framework to understand, prevent and respond to harmful sexual behaviours in detention, and providing access to timely, expert assessment and a range of appropriate, coordinated interventions, including therapeutic interventions
- improving laws, custodial procedures and practices for personal searches of children and young people in detention, isolation and the use of force
- ensuring children in detention, their family members and staff have appropriate mechanisms to raise child safety concerns and make complaints, and that all allegations against staff involving child sexual abuse and related conduct (including grooming and boundary breaches), or inappropriate searches, isolation or use of force are referred to the new Child-Related Incident Management Directorate for investigation and response (recommended in Chapter 6 at Recommendation 6.6)

- establishing an independent community visitor scheme to give children and young people in detention independent, trusted adults to whom they can speak regularly, with whom they can safely and confidently raise concerns, and who will advocate on their behalf (this scheme is also discussed in Chapter 9)
- strengthening and improving monitoring of Tasmania’s youth detention system by giving the new Commission for Children and Young People (recommended in Chapter 18 at Recommendation 18.6) responsibility for inspecting detention facilities and monitoring the safety and wellbeing of children and young people in detention.

## 1.2 Structure of this chapter

This chapter is structured as follows.

Section 2 outlines the Tasmanian Government’s proposed youth justice reforms over the next decade; these give important context for our recommendations.

Section 3 considers the legacy of abuse at Ashley Youth Detention Centre and makes recommendations to close the Centre as soon as possible, establish a memorial to victim-survivors who experienced abuse at the Centre, develop a process to preserve historical records relating to children, young people and staff at the Centre, and audit past claims of abuse.

Section 4 examines the culture at Ashley Youth Detention Centre and considers the changes needed in the areas of leadership, governance, children’s participation and staffing to implement a child safe culture in youth detention where the risk of child sexual abuse is minimised.

Section 5 discusses ways to reduce the number of children and young people entering the youth detention system, including remand, so fewer children and young people are exposed to the risk of child sexual abuse in detention, and community safety is better served.

Section 6 focuses on the improvements needed to create an effective, child-focused detention system that meets the complex needs of children and young people in detention, minimises the risks of child sexual abuse and reduces reoffending.

Section 7 makes recommendations to address the over-representation of Aboriginal children and young people in detention and strengthen cultural safety in detention facilities, with a view to minimising the risk of sexual abuse for Aboriginal children and young people in detention.

Section 8 focuses on harmful sexual behaviours in youth detention (highlighted in Chapter 11, Case study 2) and makes recommendations to prevent these behaviours and significantly improve responses to them when they occur.

Section 9 examines the laws, standards, policies and procedures that apply to personal searches of children and young people in detention, isolation practices (highlighted in Chapter 11, Case study 3) and the use of force (highlighted in Chapter 11, Case study 4)—practices that sometimes involved or were connected to child sexual abuse.

Section 10 considers channels within the Department for Education, Children and Young People through which children and young people in detention, their families and staff of detention facilities can raise concerns or make complaints about child safety, including child sexual abuse, and the Department’s responses to these concerns and complaints.

Section 11 examines independent oversight of the youth detention system and makes recommendations to strengthen independent advocacy for children and young people in detention and systemic monitoring of the youth justice system.

## 2 The Government’s youth justice reform agenda

On 9 September 2021, the then Premier, the Honourable Peter Gutwein MP, announced that Ashley Youth Detention Centre would close ‘in around three years’ and be replaced by ‘two new smaller facilities’ because it was ‘time for a major systemic change in our youth justice system’.<sup>1</sup> This announcement followed more than a decade of calls from stakeholders to close Ashley Youth Detention Centre.<sup>2</sup>

In August 2022, the Tasmanian Government reaffirmed its commitment to close Ashley Youth Detention Centre by the end of 2024.<sup>3</sup>

On 22 November 2022, the Minister for Education, Children and Youth, the Honourable Roger Jaensch MP, announced the Government’s plans for reform of the entire youth justice system, stating that the Government was:

... determined to build a nation-leading approach that engages at-risk young people early, directs them away from the youth justice system and supports young people who come into conflict with the law to become valued and productive members of our community.<sup>4</sup>

Minister Jaensch stated that, as part of these reforms, the Government would establish new youth justice facilities, including:

- a new statewide detention/remand centre in southern Tasmania that would ‘provide intensive intervention and rehabilitation through a therapeutic model of care’
- two assisted bail facilities—one in northern Tasmania or the North West, and one in southern Tasmania—to ‘reduce the number of young people remanded to a detention centre’

- two ‘supported residential facilities’—one in northern Tasmania or the North West, and one in southern Tasmania—to support ‘transition for young people from detention to independence’.<sup>5</sup>

We commend the Tasmanian Government for its decision to close Ashley Youth Detention Centre and for acknowledging the need to reform the youth justice system. We discuss the closure of Ashley Youth Detention Centre in Section 3.1.

In this section, we outline three documents the Tasmanian Government gave us towards the end of our Commission of Inquiry that describe the Government’s planned reforms to the youth justice system, including youth detention. We discuss specific elements of these documents throughout this chapter.

## 2.1 Keeping Kids Safe Plan

In late October 2022, the Tasmanian Government gave us a document titled *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre until Its Intended Closure* (‘Keeping Kids Safe Plan’).<sup>6</sup> This document details existing and proposed safeguards for children and young people at Ashley Youth Detention Centre.

According to the Keeping Kids Safe Plan, existing safeguards include:

- the *Children, Youth and Families Practice Manual* (‘Practice Manual’), which provides ‘a comprehensive set’ of policies, procedures and practice requirements relevant to custodial youth justice<sup>7</sup>
- the *Ashley Youth Detention Centre Practice Framework*, which was developed in 2020 to guide therapeutic approaches at the Centre—this framework ‘utilises a strengths-based approach to assist in building relationships that foster safety, communication, respect and achievement of goals resulting in healthy children and young people and staff’<sup>8</sup>
- a *Learning and Development Framework*, which ‘sets expectations for learning and skill development of all staff’ at the Centre<sup>9</sup>
- upgrades to the Centre’s facilities between 2019 and 2022 to increase safety and to effect a therapeutic approach to detaining children and young people<sup>10</sup>
- independent oversight of the Centre by the Commissioner for Children and Young People and the Custodial Inspector.<sup>11</sup>

The Keeping Kids Safe Plan commits the Tasmanian Government to implementing more safeguards through a safety plan comprising 22 actions to meet the following objectives:

1. increasing safety and security for children and young people
2. maintaining an appropriate level of staff with the right experience and competencies

3. delivering a therapeutic service model
4. implementing practice improvements.<sup>12</sup>

A working group will oversee the implementation of actions under the Keeping Kids Safe Plan.<sup>13</sup>

## 2.2 Draft Youth Justice Blueprint 2022–2032

The Government also gave us its *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System* ('Draft Youth Justice Blueprint').<sup>14</sup> This document is not yet publicly available, but the Government advised us that it will be finalised after the Government receives our final recommendations.<sup>15</sup> We refer to the Draft Youth Justice Blueprint throughout this chapter as the most current outline of the Government's reform plans for the youth justice system over the next decade.

The overarching goal of the Draft Youth Justice Blueprint is 'to reduce the involvement of children and young people in the youth justice system'.<sup>16</sup> Its key objective is 'to create a contemporary youth justice system' that:

- prevents children and young people's contact with the youth justice system
- addresses offending behaviour
- addresses the over-representation of Aboriginal children and young people in the youth justice system
- keeps children and young people in detention safe
- 'supports children and young people to re-enter the community through prosocial pathways'
- improves community safety.<sup>17</sup>

Eight principles underpin the Draft Youth Justice Blueprint. These principles emphasise the importance of children and young people's rights, safety and wellbeing.<sup>18</sup> The Draft Youth Justice Blueprint also notes the need to strengthen connection to family, community and culture for Aboriginal children and young people in the youth justice system and 'includes an increased focus on self-determination of Aboriginal communities'.<sup>19</sup>

The Draft Youth Justice Blueprint lists the following five strategies:

1. prioritise prevention and early intervention to reduce engagement with the youth justice system
2. ensure diversion from the justice system is early and lasting
3. establish a therapeutically based criminal justice response for children and young people



4. integrate and connect whole of government and community service systems
5. provide an appropriately trained and supported therapeutic workforce.<sup>20</sup>

It also foreshadows the development of a ‘Blueprint Monitoring and Evaluation Plan’.<sup>21</sup>

The Draft Youth Justice Blueprint was developed in consultation with government agencies, representatives of Tasmania’s Aboriginal communities, the Commissioner for Children and Young People, non-government organisations and children and young people with lived experience of the youth justice system, as well as their families.<sup>22</sup> The Government intends to engage with children and young people and Aboriginal communities to implement the Youth Justice Blueprint.<sup>23</sup>

Several action plans will support the Youth Justice Blueprint.<sup>24</sup> We give an overview of the *Draft First Action Plan 2023–2025* (‘Draft First Action Plan’) in the following section.

## 2.3 Draft First Action Plan 2023–2025

We received the Department’s Draft First Action Plan, produced in January 2023, which is the first in a series of action plans designed to implement the Youth Justice Blueprint.<sup>25</sup>

The Draft First Action Plan aims to deliver seven ‘priority’ actions by 2025:

1. ‘Enhance the safety and therapeutic approach’ at Ashley Youth Detention Centre—this action focuses on responding to the public hearings of our Commission of Inquiry.<sup>26</sup>
2. ‘Develop and implement a Youth Justice Model of Care’ to ‘facilitate therapeutic, trauma informed and culturally safe service delivery to improve the wellbeing of children and young people to reduce their involvement in the youth justice system’.<sup>27</sup>
3. Review the *Youth Justice Act 1997* (‘Youth Justice Act’)—this action includes legislative changes to implement the Government’s commitment to increase the minimum age of detention from 10 to 14 years.<sup>28</sup>
4. ‘Implement a range of diversion, bail support and community-based sentencing options’—this action includes developing a ‘Diversionary Services Framework’.<sup>29</sup>
5. ‘Design and construct new purpose-built youth justice facilities’ to replace Ashley Youth Detention Centre.<sup>30</sup>
6. ‘Operationalise’ the new youth justice facilities—this action includes defining workforce requirements and recruiting staff.<sup>31</sup>
7. ‘Develop and implement an alternative education model’—this action involves designing new approaches to meet the needs of children and young people who are at risk of disengaging from education.<sup>32</sup>

The Department for Education, Children and Young People is the lead agency for all seven actions.<sup>33</sup>

We turn now to our recommendations for reform.

### 3 Addressing the legacy of abuse

In Chapter 11, Case study 1, we describe what we heard about the nature and extent of abuse at Ashley Youth Detention Centre. While it was not possible for our Commission of Inquiry to test the veracity of every allegation outlined in victim-survivors' accounts, we were struck by the similarities and common themes across these accounts. In Case study 1, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse—that many children were systematically dehumanised, brutalised and degraded while at the Centre. This finding is based on all the evidence we reviewed—from victim-survivors and their families, current and former Centre staff, senior management in the Department, the many prior reports and investigations into the Centre, allegations made through civil and redress scheme claims, and the insights of relevant experts into organisational misconduct. It is a sobering finding.

Child sexual abuse can have a profound and lasting impact on victim-survivors. Case study 1 describes the devastating ongoing trauma that the abuse at Ashley Youth Detention Centre has had on victim-survivors' mental and physical health. We heard that many victim-survivors have attempted suicide, experience significant mental health conditions, struggle with addictions to drugs and alcohol, have difficulties forming and maintaining relationships and have been incarcerated during their adult lives.

Child sexual abuse in institutions, particularly at the scale we heard alleged at Ashley Youth Detention Centre, also has a profound effect on the people working in those institutions, who may have been colleagues with those who have offended, or against whom allegations have been made. We discuss the impacts on staff in Section 4.7. In this section, we focus on addressing the impacts of abuse of this scale on children and young people in detention.

As noted in Chapter 11, Case study 1, victim-survivors and their family members told us that they wanted an acknowledgment from the Tasmanian Government about what has happened to them. On 8 November 2022, the Tasmanian Parliament delivered an apology to victim-survivors of child sexual abuse in government institutions, in which it:

Expresse[d] its deep, unreserved sorrow on behalf of all Tasmanians, to all victims/survivors of institutional child sexual abuse and apologise[d] for the pain, suffering and trauma they have endured through previous actions and inactions by those in authority.<sup>34</sup>

The apology did not specifically refer to victim-survivors of abuse at Ashley Youth Detention Centre.

It is essential to ensure the systematic harm and abuse that occurred at Ashley Youth Detention Centre, and the pain, suffering and trauma endured by victim-survivors, are not forgotten. In his apology, the Premier, the Honourable Jeremy Rockliff MP, said:

Over the past eight months throughout this inquiry we have heard about a very, very dark chapter in Tasmania’s history. It is a chapter no-one should ever forget. Today we give a solemn undertaking to all Tasmanians to never allow a repeat of this abuse, of the secrecy and the suppression: to never allow a repeat of the failures that allowed such abuse to occur.<sup>35</sup>

In this section, we consider the legacy of abuse at Ashley Youth Detention Centre and recommend that the Tasmanian Government:

- closes the Centre and creates a memorial to victim-survivors who experienced abuse at the Centre
- ensures any person who has previously been detained at Ashley Youth Detention Centre is not detained or imprisoned at any new correctional facility on the same site (unless they so choose)
- preserves Ashley Youth Detention Centre records, so they are available for any victim-survivors who may wish to seek redress
- commissions an audit of allegations of child sexual abuse arising through state and national redress schemes, civil claims and complaints to ensure children and young people in detention, out of home care and other institutions are protected against any risks of child sexual abuse.

### 3.1 Closing Ashley Youth Detention Centre

Victim-survivors told us that Ashley Youth Detention Centre should be closed. One victim-survivor, Fred (a pseudonym), said:

... just close this place down and start again, because ... it’s systemic, it’s grown in that environment. You won’t ever get rid of it by putting in new staff members or changing things: tear the place down and start again, the memories are too— just appalling.<sup>36</sup>

Similarly, Professor Robert White, Emeritus Distinguished Professor of Criminology, University of Tasmania, said:

I would raze Ashley to the ground. I would destroy the physical infrastructure tomorrow, I wouldn’t wait, and we don’t have three years of transition: I would get rid of it immediately and transfer the children to other places, houses, secure houses or whatever, but I would certainly knock it down.<sup>37</sup>

As noted in Section 2, the Tasmanian Government has previously announced its intention to close Ashley Youth Detention Centre by the end of 2024. On 13 July 2023, Minister Jaensch cast doubt on this closure date. In evidence to a parliamentary inquiry on adult imprisonment and youth detention, the Minister said:

When we announced our intention to not just replace Ashley with two smaller Ashleys, we also then realised that delivering this more sophisticated, better-practice model may take more time and so whilst we have remained committed to the ambition of closing Ashley as soon as possible, and 2024 is the date that was announced, we believe that is going to need to be updated. Now, what I do not want to do is to issue another political deadline. What I want to do, as soon as possible, and I hope to be able to do in coming months, is once we have confirmed the preferred site for the development of the southern detention facility, which is a critical component of the new facilities delivery model, once we have an actual site that we have locked in, then we can conduct the remaining site investigations, planning and design processes, then we will know how much it will cost and how long it will take to build that and my next step, in terms of clarifying time frames, will be to provide a firm, actual time frame based on those investigations, so I hope to do that in coming months.<sup>38</sup>

While we acknowledge the Government's restated commitment to closing Ashley Youth Detention Centre, we are gravely concerned by any suggestion of further delay. The Government must close Ashley Youth Detention Centre as soon as possible. We discuss the future use of the site in Section 3.3.

### **Recommendation 12.1**

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

## **3.2 Creating a memorial to victim-survivors**

As discussed in Chapter 15, child sexual abuse can constitute a collective trauma event, requiring a response that promotes community care and the restoration of trust. In acknowledging past wrongs and suffering, and providing space for grief, healing and remembrance, a memorial can be an important part of the response to such an event. The National Royal Commission observed that:

Memorials can provide symbolic reparation and public recognition to victims and survivors in ways that can contribute to healing. Memorials honour those who have suffered and provide opportunities to remember the past and think about the future. They provide a specific place for families and wider society to reflect on the trauma

of survivors and mourn the victims lost. They may also serve to educate future generations about what occurred in a society's history and provide a space for public awareness and remembrance.<sup>39</sup>

The National Royal Commission recommended that the Australian Government commission a national memorial for victims and survivors of child sexual abuse in institutional contexts to be located in Canberra and designed in consultation with victim-survivors.<sup>40</sup> A design for the national memorial was selected in January 2022.<sup>41</sup>

Memorials to victim-survivors of abuse have also been recommended in international inquiries on institutional child abuse, including inquiries in Ireland and Jersey.<sup>42</sup> In recommending a memorial to victim-survivors of child abuse in institutions, the Irish Commission to Inquire into Child Abuse said in 2009:

It is important for the alleviation of the effects of childhood abuse that the State's formal recognition of the abuse that occurred and the suffering of the victims should be preserved in a permanent place ...<sup>43</sup>

The Irish inquiry also recommended that the following words of apology be inscribed on the memorial:

On behalf of the State and of all citizens of the State, the Government wishes to make a sincere and long overdue apology to the victims of childhood abuse, for our collective failure to intervene, to detect their pain, to come to their rescue.<sup>44</sup>

In 2017, the Independent Jersey Care Inquiry recommended 'some form of tangible public acknowledgment' for victim-survivors to 'allow experiences of those generations of Jersey children whose lives and suffering worsened because of failures in the care system to be respected and honoured in decades to come'.<sup>45</sup> That inquiry recommended that the form of this acknowledgment consider the views of victim-survivors.<sup>46</sup>

As noted, we heard that victim-survivors and their families wanted an acknowledgment of abuse that occurred at Ashley Youth Detention Centre and its devastating effects. As part of its apology to victim-survivors of child sexual abuse in institutions, and in recognition of the protracted, widespread and systematic nature of the abuse at Ashley Youth Detention Centre, we recommend that the Tasmanian Government creates a memorial to victim-survivors who experienced abuse at the Centre.

The Government should consult with victim-survivors to determine the form and location of the memorial—for example, a memorial garden could be established on part of the site, similar to the one established in memory of the 1996 Port Arthur massacre.<sup>47</sup> While we acknowledge the Government's plans to redevelop the Ashley Youth Detention Centre site (discussed in Section 3.3), we do not consider that this precludes creating a memorial at the site.

## Recommendation 12.2

Once Ashley Youth Detention Centre is closed, the Tasmanian Government should establish a memorial to victim-survivors who experienced abuse at the Centre.

The form and location of the memorial should be decided in consultation with victim-survivors of abuse at Ashley Youth Detention Centre.

### 3.3 Future use of the site—avoiding further trauma

In December 2021, the Honourable Elise Archer MP, Attorney-General and Minister for Corrections, released a statement indicating that the Department of Justice would begin a community consultation process to learn the views of the local community on the future use of the Ashley Youth Detention Centre site.<sup>48</sup> This statement revealed that an initial evaluation indicated the site would be ‘well suited for a modern, state-of-the art correctional facility in Northern Tasmania with a rehabilitative focus’.<sup>49</sup> According to the Minister, the proposed correctional facility project would ‘create jobs and investment in the North’.<sup>50</sup>

The Department of Justice is currently undertaking ‘due diligence investigations required as part of the normal statutory planning process’ for redeveloping the Ashley Youth Detention Centre site.<sup>51</sup> In particular, the Department of Justice has engaged ‘social planning consultants’ to prepare a social impact assessment for the project—this includes ‘investigating issues raised by the community and ... recommend[ing] ways to minimise potential impacts’.<sup>52</sup> At the time of writing, the Government had not published this assessment.

The community consultation undertaken by the Department of Justice in 2022 on the future use of the Ashley Youth Detention Centre site does not appear to have specifically sought the views of those who had previously been detained at the Centre.<sup>53</sup>

Victim-survivor Simon (a pseudonym) described his concerns at the prospect of converting the Ashley Youth Detention Centre facilities into a prison:

Ashley shouldn’t be put into a jail. What about people with memories, they’re going to lay their head down and think they’ve been abused, you know what I mean?<sup>54</sup>

Media reports also indicate that some community members opposed the plan for a northern correctional facility at the Ashley Youth Detention Centre site during a consultation session held in February 2023.<sup>55</sup>

We are concerned by the Tasmanian Government’s plans to turn the Ashley Youth Detention Centre site into an adult correctional facility. As discussed in Section 5.1.1, many children and young people detained at Ashley Youth Detention Centre go on to serve a term of imprisonment in an adult prison. We are therefore concerned that



victim-survivors of child sexual abuse at Ashley Youth Detention Centre may, as adults, be sent to an adult prison located on the site where that abuse occurred. As Simon indicated, this is likely to be retraumatising.

For these reasons we recommend that the Tasmanian Government ensures no person who has previously been detained at Ashley Youth Detention Centre be remanded or imprisoned at any adult correctional facility at the same site, unless they so choose—for example, to be close to family.

### **Recommendation 12.3**

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

## **3.4 Preserving Ashley Youth Detention Centre records**

As discussed in Chapter 17 on civil litigation and redress, records are critically important to victim-survivors of child sexual abuse because they can offer important corroborative evidence for redress claims and help victim-survivors understand their past experiences.<sup>56</sup> Records can also provide an important evidentiary basis for initiating criminal or disciplinary proceedings. Inadequate records and record keeping contribute to failures in identifying and responding to risks and incidents of child sexual abuse, and exacerbate distress for victim-survivors.<sup>57</sup>

As discussed in Chapter 11, Case study 7, we heard that record keeping at Ashley Youth Detention Centre was deficient. In particular, we heard that records at the Centre were ‘hard copy’ rather than electronic and were stored in various locations at the Centre, including cabinets, unlabelled boxes and ‘random places’.<sup>58</sup> Stuart Watson, Manager, Custodial Youth Justice (‘Centre Manager’), told us that, in 2020, ‘[t]here was an entire room the size of a garage full of paper files that went back for years and years and years’ in the ‘Training Cottage’ at Ashley Youth Detention Centre.<sup>59</sup> He indicated that these records and others had since been sent to ‘central archiving’ for electronic filing.<sup>60</sup>

Mr Watson also told us that ‘[t]here just wasn’t easily accessible information and people didn’t know where information was’, suggesting that records at Ashley Youth Detention Centre were not filed, indexed, catalogued or archived appropriately.<sup>61</sup> We heard that some items, such as ‘photographs, maps and rosters’, may not have been understood to be official records and were therefore not filed appropriately.<sup>62</sup> The Department advised us that it lacked documented policies and procedures for record keeping.<sup>63</sup>

As discussed in Chapter 11, Case study 7, we heard that the Department’s poor record-keeping practices contributed to delays in responding to allegations of child sexual abuse.<sup>64</sup> In particular, we heard that, because records had not been catalogued or indexed, accessing relevant information to establish facts, timeframes and key events relating to allegations—for example, to determine whether a person was employed at Ashley Youth Detention Centre at the time of the alleged abuse—was time-consuming and labour-intensive.<sup>65</sup>

Deficiencies in record keeping also meant that victim-survivors experienced difficulties and delays in obtaining their records from Ashley Youth Detention Centre, which caused distress, trauma, pain and frustration.<sup>66</sup>

The Department acknowledged the poor quality of its record keeping, stating that incident-recording processes at Ashley Youth Detention Centre were ‘likely to have been unreliable for some of the period from 2002–2020’.<sup>67</sup>

In May 2021, the former Department of Communities initiated the Records Digitisation and Remediation Project to centralise historical records, with an initial focus on Ashley Youth Detention Centre records.<sup>68</sup> According to the ‘Project Initiation Document’, ‘[i]nitially, the intent was simply to digitise all hard copy holdings, including those at the Archives office of Tasmania and with off-site storage holders’.<sup>69</sup> However, early work revealed more than 8,000 boxes and 150,000 hard copy records, with ‘a large variety and volume of documents in formats that are difficult to digitise and impossible to render text searchable’, which led to the project’s scope being refined.<sup>70</sup>

The objective of the refined project was to ensure the Department could ‘access its historical records and meet its obligations to the Commission of Inquiry, National Redress [Scheme], victims, and the community’.<sup>71</sup> Its scope was described as ‘[s]canning and remediation of relevant or potentially relevant records from 1 January 2000 or relating to alleged incidents lodged after 1 January 2000’.<sup>72</sup> Key outputs of the project were described as digitising hard copy records and remediating legacy electronic or hard copy records that were ‘potentially of interest to the Commission of Inquiry or immediately relevant to information requests which have been received’.<sup>73</sup>

According to the National Royal Commission, ‘[d]igitising archival records can be expected to increase search ability and reduce risk of loss’, but ‘digital technology also presents new challenges and risks, including costs of upkeep and updating, corruption and security of files and technological obsolescence’.<sup>74</sup>

We commend the Department’s Records Digitisation and Remediation Project and acknowledge the enormity of the task. However, it is not clear to us that the Department has digitised all necessary records. In particular, we note that the project does not include records created before 2000. Also, while we appreciate the need to focus on responding to our Commission of Inquiry and to other information requests

received by the Department, we are concerned that important information in other records potentially relevant to future claims from victim-survivors may not have been captured. We are also unaware of what active steps are being taken to preserve records relating to children and young people in out of home care, some of whom may also have experienced youth detention.<sup>75</sup>

It is also not clear to us what the Department's plans are for retaining and maintaining the physical records it has digitised. Some physical records may hold tremendous personal significance for victim-survivors of abuse at Ashley Youth Detention Centre. However, we also recognise that adequately maintaining large volumes of physical records for extended periods may be impractical for the Department. Physical files require storage in appropriate conditions to prevent damage or destruction (for example, by fire, floods or vermin).<sup>76</sup> The National Royal Commission indicated that '[n]ot all records are, or should be, archived and retained in perpetuity, and it may be appropriate that certain records be destroyed'.<sup>77</sup>

In line with the National Royal Commission's recommended principle for maintaining records, the Department should, at a minimum, ensure its records are:

... up to date; indexed in a logical manner that facilitates easy location, retrieval and association of related information; and preserved in a suitable physical or digital environment that ensures the records are not subject to degradation, loss, alteration or corruption.<sup>78</sup>

More specifically, the Department must ensure it keeps records that may be relevant to future allegations of child sexual abuse. As outlined in Chapter 17, the National Royal Commission recommended that the National Archives of Australia and state and territory public records authorities guide government and non-government institutions on identifying records that, it is reasonable to expect, may become relevant to an actual or alleged incident of child sexual abuse, and on retaining and disposing of such records.<sup>79</sup>

In response to this recommendation, the Tasmanian Office of the State Archivist has outlined, for various institutions, the types of records 'that may become relevant for National Redress Scheme applicants, or for people taking legal action for abuse suffered when they were children'.<sup>80</sup> For youth justice, these records are:

- 'Youth offender case files, including investigations, prosecution, sentencing etc'
- 'Records of a youth offender's location, including custodial arrangements, community service activities and transport'
- 'Complaints and grievances'
- 'Records of at-risk youths'
- 'Restorative justice services to child victims of crime'.<sup>81</sup>

While these descriptions are broad, we consider that there are other records such as staff rosters and the daily roll that may include important information relevant to allegations of child sexual abuse in youth detention.

We recommend that the Department for Education, Children and Young People build on its Records Digitisation and Remediation Project by working with the Office of the State Archivist to establish an approach to preserving historical records relevant to children and young people and staff at Ashley Youth Detention Centre. A similar approach should be taken for records about other children in state care, including children in out of home care, as well as staff and carers connected with state care.

Managing this material will enable the Department to make all necessary reports to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme (this is discussed in Section 3.5).

### **Recommendation 12.4**

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

- a. establish a process to identify, recover, restore, collate, digitise, index and catalogue all historical records relating to children and young people and staff at Ashley Youth Detention Centre, and all other children in, or staff or carers connected with, state care
- b. ensure digitised records are searchable, retrievable, secure and protected against corruption or loss
- c. determine which physical records should be retained following digitisation, and maintain these physical records in line with the National Royal Commission's record-keeping principles
- d. determine protocols and guidance on how people who have been detained at Ashley Youth Detention Centre can access their records.

## **3.5 Undertaking an audit of allegations**

The Tasmanian Government holds substantial information about allegations of child sexual abuse by current and former staff of Ashley Youth Detention Centre. As discussed in Chapter 11, Case study 1, this information arises from:

- claims made under the Abuse in State Care Program, which the Tasmanian Government ran between 2003 and 2013

- claims made under the Abuse in State Care Support Service, which the Tasmanian Government has run since 2013
- applications under the National Redress Scheme, run by the Australian Government since 2018
- civil claims made against the Tasmanian Government in respect of vicarious liability for the conduct of its staff, or liability for failing to protect a child from abuse
- complaints and allegations received by the Government directly from children and young people who are or were detained at Ashley Youth Detention Centre, or from others with knowledge of alleged abuse at the Centre
- sworn statements to our Commission of Inquiry from lived experience witnesses who were detained at Ashley Youth Detention Centre.

A significant number of allegations made in claims under the Abuse in State Care Program also concerned abuse by staff and carers in the out of home care system.<sup>82</sup> This is discussed in Chapter 8. There were also claims made about abuse in other state institutions, including hospitals and religious organisations.<sup>83</sup> Claims under the Abuse in State Care Support Service and the National Redress Scheme and civil claims may also relate to staff and carers in the out of home care system and other state institutions.

As highlighted by Chapter 11, Case study 7, claims made through all these schemes provide important information for a number of state agencies to perform their functions in protecting children. This includes Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme.

It is essential that the Department has processes in place to assess this information and to identify and act on any ongoing risks that may be posed by those who are the subject of allegations. We heard that the Government has previously taken steps to review allegations of child sexual abuse for these purposes. These are discussed in the following sections.

### 3.5.1 The 2020 ‘cross-check’ review

As discussed in Chapter 11, Case study 7, the former Department of Communities undertook a review from September to November 2020 to crosscheck the names of alleged abusers identified in claims under the Abuse in State Care Program with current employees who had been working at Ashley Youth Detention Centre before 2010.<sup>84</sup> The review also identified what actions may have been taken where an employee had been named in an Abuse in State Care Program claim.<sup>85</sup>

The primary purpose of the review was to identify current staff who had been named in Abuse in State Care Program claims. The review did not cover all sources of information held by the Department. In particular:

- The review was limited to Abuse in State Care Program records and did not extend to allegations raised through the Abuse in State Care Support Service.<sup>86</sup>
- The Department limited its analysis to current employees who had been working at Ashley Youth Detention Centre before 2010. However, the Abuse in State Care Program ran until 2013 and the Department provided us with a spreadsheet indicating that the period of abuse that was raised in Abuse in State Care Program records spanned from 1995 to 2013.<sup>87</sup> This suggests there may have been current staff employed after 2010 who were not captured by the crosschecking exercise, and complainants may have raised allegations against staff members in respect of conduct that occurred between 2010 and 2013.
- The review did not include applications under the National Redress Scheme or civil claims.

It also did not consider out of home care system staff or carers, or staff in other government institutions.<sup>88</sup>

In September 2020, the Department identified that 127 Abuse in State Care Program claims had been made against Ashley Youth Detention Centre staff members (some of whom were named on multiple occasions) and that two current employees had been named as alleged abusers by multiple complainants.<sup>89</sup> While we understand that this review concluded in November 2020, it is unclear to us what more information was uncovered during this time.<sup>90</sup> Former Department Secretary Michael Pervan told us the review ultimately resulted in the identification of four current employees named in Abuse in State Care Program claims.<sup>91</sup>

### 3.5.2 The 2020 spreadsheet

As discussed in Chapter 11, Case study 7, in October 2020, a spreadsheet was prepared and circulated to various people in the Department that contained a list of all Ashley Youth Detention Centre staff named in the Abuse in State Care Program, the National Redress Scheme and in common law (civil) claims.<sup>92</sup>

We heard that the spreadsheet was then expanded to include allegations from information received from various sources about any alleged sexual, physical or emotional abuse, with the Department for Education, Children and Young People telling us the aim of the spreadsheet was to ‘centralise all complaints/allegations to assist in identifying trends, patterns and cumulative allegations’.<sup>93</sup> The information sources included:

- allegations from the Abuse in State Care Program against Ashley Youth Detention Centre employees and from the Abuse in State Care Support Service where these were referenced in a National Redress Investigation Report

- National Redress Scheme applications and common law negligence claims (where there was an allegation against an Ashley Youth Detention Centre employee, Ashley Youth Detention Centre detainee or out of home care foster carer)
- allegations made directly through Ashley Youth Detention Centre (for example, historical records of detainee complaints made directly to Centre management or through the Ombudsman)
- a complaint made about an Ashley Youth Detention Centre employee that was made to the Children, Youth and Families Complaints Officer.<sup>94</sup>

We note that the source material for the spreadsheet did not include:

- all Abuse in State Care Program claims
- claims under the Abuse in State Care Support Service unless they were referred to in a National Redress Scheme Investigation Report
- claims under the National Redress Scheme or civil claims about staff in other government institutions.

We heard that the spreadsheet was held and maintained by the Department's Legal Services directorate.<sup>95</sup> The legal team performed checks through the online Government Directory Service to establish whether a particular person was still employed in the State Service, although concerns were raised that this was not a robust checking mechanism.<sup>96</sup> The Department indicated that discussions occurred between Mandy Clarke, former Deputy Secretary, Children, Youth and Families, and others about the employee status of those named in the spreadsheet.<sup>97</sup>

The Department also told us, in January 2023, that the Tasmanian Government and the Department were 'actively considering these issues and [would] work collaboratively to ensure that any risk to children is minimised'.<sup>98</sup>

Given the scope of these reviews and the variable exclusions in each, it appears the Department may not have identified all relevant allegations.

### 3.5.3 Child Sexual Abuse Joint Review Team

The Tasmanian Government set up the Child Sexual Abuse Joint Review Team in February 2021.<sup>99</sup> This team was tasked with 'conducting a multi-agency review to look for potential perpetrators from where there may be multiple information reports or references relating to an individual'.<sup>100</sup> An objective of this review was 'to identify potential child sex offenders in the community with a view to ensuring all avenues of investigation are exhausted so that offenders can be brought to justice'.<sup>101</sup> The Child Sexual Abuse Joint Review Team was led by Tasmania Police and overseen by a high-level steering committee.<sup>102</sup>



This review relied on data from the police intelligence database ('Atlas'), the Registration to Work with Vulnerable People database and the former Department of Communities Child Protection Information System and Children's Advice and Referral Digital Interface.<sup>103</sup> The review 'did not use a list of Officials from Ashley Youth Detention Centre as a base data set in the data matching work that was undertaken'.<sup>104</sup>

Jonathan Higgins APM, then Assistant Commissioner of Operations, Tasmania Police, told us the Child Sexual Abuse Joint Review Team's data-matching work involved comparing data and:

... where two or three point matches were identified, the information was reviewed. Reviews may have included individuals who were Officials from Ashley Youth Detention Centre however search parameters did not specifically target those individuals.<sup>105</sup>

Assistant Commissioner Higgins also stated that the Child Sexual Abuse Joint Review Team was not given separate material in respect of the Abuse in State Care Program.<sup>106</sup> As such, the Child Sexual Abuse Joint Review Team did not capture all relevant information pertaining to allegations of child sexual abuse at Ashley Youth Detention Centre or in out of home care (or, indeed, across government institutions).

Former Commissioner of Police Darren Hine AO APM told us the Child Sexual Abuse Joint Review Team reviewed 136,000 people who were registered to work with vulnerable people in Tasmania and 'did not identify children at current risk due to Tasmania Police or Department of Communities inaction at a point in time'.<sup>107</sup>

### 3.5.4 Process for notifying relevant agencies

As discussed in Chapter 11, Case study 7, when the Tasmanian Government receives allegations of child sexual abuse, it is obligated to notify various authorities, including Tasmania Police (about suspected criminal conduct) and the Registrar of the Registration to Work with Vulnerable People Scheme (about 'reportable behaviour' under the *Registration to Work with Vulnerable People Act 2013*).<sup>108</sup>

The former Registrar of the Registration to Work with Vulnerable People Scheme, Peter Graham, told us that 'a systemic review of past complaints or investigations' would likely reveal information that meets the definition of 'reportable behaviour'.<sup>109</sup> Notifying the Registrar of allegations that may constitute reportable behaviour is essential, so the Registrar can take appropriate action in respect of people who hold current registrations to work with children and young people.

There are also mandatory reporting obligations to report to Child Safety Services under sections 13 and 14 of the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') where there is a risk of child abuse or neglect.

In addition, a notification may be required to the Independent Regulator of the Reportable Conduct Scheme under the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act') about a 'reportable allegation'.<sup>110</sup> A 'reportable allegation' is information that leads a person to form a reasonable suspicion that a worker of a relevant entity (including a youth detention facility) has committed 'reportable conduct' (including sexual misconduct), regardless of whether the alleged conduct occurred before the commencement of the Act.<sup>111</sup> The Reportable Conduct Scheme is discussed in detail in Chapter 18.

We are concerned that notifications to authorities have not always occurred in a timely manner for allegations in National Redress Scheme applications. In Chapter 11, Case study 7, we find that:

- the Department of Justice does not have an appropriate process to ensure information in National Redress Scheme applications is shared in a timely manner to protect children
- the Department of Communities did not take appropriate steps to make appropriate notifications
- Tasmania Police should improve its information-sharing and referral practices to ensure other agencies (including Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme) receive information, where appropriate, to enable those agencies to take steps to protect the safety of detainees.

The *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) permits the disclosure of 'protected information' obtained by a government institution if required for the enforcement of criminal law, the safety or wellbeing of children, or investigatory, disciplinary or employment processes related to the safety or wellbeing of children (among other purposes).<sup>112</sup> This enables government institutions (such as the Department of Justice) to comply with mandatory reporting legislation and reportable conduct schemes.<sup>113</sup>

Within the Tasmanian Government, the Department of Justice is often the first recipient of information about National Redress Scheme applications and the holder of the most complete information from those applications available to the Government.

As outlined in Chapter 17 and Chapter 11, Case study 7, the Child Abuse Royal Commission Response Unit in the Department of Justice coordinates the Tasmanian Government's response to National Redress Scheme applications.<sup>114</sup> Ginna Webster, Secretary, Department of Justice, told us that when the National Redress Scheme Operator identifies the Tasmanian Government as potentially responsible for the alleged abuse, the Operator notifies the Tasmanian Government of the application and gives it a limited time in which to provide necessary information in response.<sup>115</sup>

The Government told us the Department of Justice does not receive the full application from the National Redress Scheme Operator; rather, it receives ‘redacted and curated components of the application’.<sup>116</sup>

In June 2022, Secretary Webster told us that the Child Abuse Royal Commission Response Unit summarises the application and sends the relevant department a ‘National Redress Scheme – Request for Information’ form, which includes the summary of the application and requests a records search.<sup>117</sup> The form has questions about whether the department holds records that document the abuse, whether there are any records of a prior payment to the complainant (for example, an ex gratia payment) and whether there are records that show the alleged abuser is still a government employee or working in a child-related activity.

Secretary Webster told us:

In referrals to an Agency/agencies, [the Child Abuse Royal Commission Response Unit] include[s] details of the alleged abuser to enable the Agency to undertake enquiries as to whether the abuser is a current employee or a continuing risk to children. If the abuser is identified and remains affiliated with the Agency the matter is dealt with through the Agency’s own internal policies.<sup>118</sup>

The summary of the National Redress Scheme application that is prepared by the Department of Justice’s Child Abuse Royal Commission Response Unit and provided to the relevant department may contain insufficient details for that department to identify whether an allegation involves suspected criminal conduct or reportable behaviour. This includes where there is a lack of sufficient detail within the initial National Redress Scheme application.

In July 2023, the Government told us that, from mid-late 2020, the Department of Justice changed its practice and started providing departments with the ‘full’ National Redress Scheme application that it receives from the National Redress Scheme Operator, rather than a summary.<sup>119</sup> The Government also told us that, in January 2021, the Child Abuse Royal Commission Response Unit undertook an audit of National Redress Scheme applications received to date and agency responses ‘to ensure all details were matched’.<sup>120</sup> We welcome these initiatives.

In response to our question as to what action the Tasmanian Government takes in relation to information acquired during the National Redress Scheme process beyond responding to the individual application (for example, reporting to Tasmania Police), Secretary Webster told us:<sup>121</sup>

The Department [of Justice] does not use the information obtained through redress applications for any purpose outside responding to the [National Redress] Scheme Operator save for reporting on de-identified figures in annual reports.<sup>122</sup>

The Government told us that the National Redress Scheme is responsible for reporting to Australian law enforcement agencies.<sup>123</sup> According to the National Redress Scheme's *Operational Manual for Participating Institutions*, the National Redress Scheme reports child abuse to police where the applicant consents to such a report being made.<sup>124</sup> Consent is sought '[d]uring initial contact with the applicant or at any other relevant time during the assessment process'.<sup>125</sup>

In addition, the National Redress Scheme reports child abuse to police, regardless of the applicant's wishes, where:

- the applicant is under the age of 18 years
- the abuse occurred in the last 10 years
- there is any other reason that children may be at risk of being abused
- the alleged abuser is still working with children, or
- the alleged abuser has their own children.<sup>126</sup>

We note that whether the alleged abuser is still working with children, or there is any other reason that children may be at risk of being abused, are matters that the relevant jurisdiction may be better placed to identify than the National Redress Scheme Operator. This means that, often, the Operator will not have reported to Tasmania Police when the Tasmanian Government is aware of these risks and could make a report.

The Government told us that requiring the Department of Justice to report to Tasmania Police based on the information it receives from the National Redress Scheme Operator would be 'ineffectual' because:

the Department could only provide the information that it received from the [National Redress Scheme]—information that Tasmania Police should already [be] in possession of, and likely have been in possession of, for an extended period (that is, several months).<sup>127</sup>

The Government also told us that requiring the Department of Justice to notify Child Safety Services or the Registrar of the Registration to Work with Vulnerable People Scheme of information from National Redress Scheme applications 'would have no impact at all as those entities are already in receipt of that information' following mandatory reporting triggered by the entry of allegations from the National Redress Scheme into Tasmania Police's intelligence system.<sup>128</sup> The Government said:

Tasmania Police provides a broader capacity [than the Department of Justice] for the management of intelligence information (and has data arrangements with the registrar for registered persons).<sup>129</sup>

However, we note that the system for notifying police and other relevant authorities of information in National Redress Scheme applications has not always operated in the manner described by the Government. For example, in some cases we examined, the Department of Communities reported allegations from National Redress Scheme applications to Tasmania Police before Tasmania Police received the information from the National Redress Scheme Operator (refer to Case study 7).<sup>130</sup> We are not confident that the information-sharing framework for the National Redress Scheme is operating as intended.

We are also concerned that relying on other departments (such as the Department for Education, Children and Young People) to make appropriate notifications to relevant authorities may result in delay, which may create unnecessary risks to children and young people in institutions where alleged abusers may be currently employed or engaged, participate in sporting and social clubs with children, or have access to children in a familial context.

We understand the informational constraints under which the Department of Justice receives National Redress Scheme applications from the National Redress Scheme Operator. However, we consider that the Department of Justice should undertake its own reporting from the National Redress Scheme materials it receives (refer to Recommendation 12.5). This reporting should be additional to the existing reporting obligations of the National Redress Scheme Operator and others, and should not be limited by the possibility of duplicate reporting by other entities.<sup>131</sup> Such reporting should occur when the information received by the Department of Justice is, on its face, sufficient to meet established reporting thresholds.

### **3.5.5 Our recommendations**

While we commend the Tasmanian Government for its attempts to review allegations of child sexual abuse among its various information holdings, the preceding discussion highlights that these reviews have not been comprehensive. We also heard that not all departments or agencies have undertaken such reviews.<sup>132</sup> As a result, we are concerned that there may still be people working with children who are the subject of child sexual abuse allegations.

This highlights the need for a comprehensive historical audit of all relevant records held by the Government to identify all allegations of child abuse, including child sexual abuse. Relevant records for the purposes of this audit should be claims made under the Abuse in State Care Program, the Abuse in State Care Support Service and the National Redress Scheme, and civil claims or complaints in relation to Ashley Youth Detention Centre or the out of home care system.

The purpose of the audit should be to identify all current and former staff in government institutions and carers in the out of home care system, so the Government can take steps to report to external authorities all information relating to current and former staff

and carers, and consider disciplinary action for current staff members as well as prioritise the safety of children. This audit is critical to ensuring the safety of children and young people in detention and out of home care.

The audit should be conducted by a person with appropriate experience, legal standing, seniority and no conflict of interest. This may mean appointing a person or body external to government. The person who conducts the audit should be given full access to all necessary systems and information.

Information obtained from the audit on individuals who are the subject of allegations of child sexual abuse should be captured in a single, central location. Secretary Pervan said the Department generally does not track allegations that are not made directly to it because information received through redress schemes and civil claims are not kept on employee files. He noted that this is an area for reform and improvement.<sup>133</sup>

In Chapter 20 on State Service disciplinary processes, we recommend that the Government maintains a central cross-government register of misconduct concerning allegations of child sexual abuse and related conduct (Recommendation 20.9). This register should contain records of substantiated and unsubstantiated matters, including those that did not proceed to investigation. We consider that information from the audit should be added to this register.

The Government also needs to ensure any reportable behaviour identified through the audit is reported to the Registrar of the Registration to Work with Vulnerable People Scheme and Child Safety Services, any suspected criminal behaviour is reported to Tasmania Police and any reportable conduct is reported to the Independent Regulator of the Reportable Conduct Scheme, so those agencies can take appropriate action.

The Government should also establish processes to monitor and manage allegations arising from future redress claims. In Chapter 17, we recommend that the Tasmanian Government advocates at a national level for the National Redress Scheme to apply to child sexual abuse in institutions experienced on or after 1 July 2018, and, if such an extension does not occur, that the Tasmanian Government itself establishes a redress scheme for victim-survivors of child sexual abuse in Tasmanian Government institutions (Recommendation 17.1).

We consider that the Department of Justice should ensure it meets its obligations to make appropriate notifications to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme (despite the fact that the Department of Justice may not be the head of the relevant entity under the Child and Youth Safe Organisations Act).

To assist other departments to identify alleged abusers who may still be working with children, and to take appropriate disciplinary action and make appropriate reports, the Department of Justice should continue to pass on full details of National Redress Scheme applications to other departments, rather than a summary.

In addition, the Government should advocate nationally for a review of the information-sharing framework in the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) and the National Redress Scheme's *Operational Manual for Participating Institutions* to ensure information about current risks to children is reported to relevant authorities in the most timely manner and by the most appropriate entity, and to identify the most appropriate point in the process for the National Redress Scheme Operator to seek consent from applicants to share information with relevant authorities.

The Government should also make appropriate supports available to victim-survivors who disclose abuse at Ashley Youth Detention Centre and who come to its attention through any State-based redress scheme, civil claim or complaint. These supports should include warm referrals, with permission, to sexual assault counsellors who have training and experience in working with victim-survivors of child sexual abuse. Warm referrals involve personally assisting victim-survivors to access a service rather than simply providing them with information about how to seek support themselves.

## Recommendation 12.5

The Tasmanian Government should:

- a. conduct an audit of allegations arising from
  - i. claims made under the Abuse in State Care Program, the Abuse in State Care Support Service and the National Redress Scheme
  - ii. civil claims in relation to Ashley Youth Detention Centre or the out of home care system
  - iii. complaints regarding Ashley Youth Detention Centre or the out of home care system

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

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



- c. ensure all relevant information derived from the audit is provided to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, disciplinary action is considered, and the current safety of children in institutions prioritised
- d. require the Department of Justice to
  - i. pass on to the Department for Education, Children and Young People and other relevant departments as a matter of urgency the full details (rather than a summary) of any relevant National Redress Scheme application or claim under any future state redress scheme that the Department of Justice administers
  - ii. make appropriate notifications to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* in relation to allegations in National Redress Scheme applications or claims under a future state redress scheme
- e. advocate at a national level to review the information-sharing framework in the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) and the National Redress Scheme's *Operational Manual for Participating Institutions* to
  - i. ensure information about current risks to children is reported to police, child protection authorities, authorities responsible for registration to work with children and administrators of reportable conduct schemes in the timeliest manner and by the most appropriate entity
  - ii. identify the most appropriate point in the process for the National Redress Scheme Operator to seek consent from applicants to share information with relevant authorities
- f. implement systems to enable future monitoring of National Redress Scheme applications, claims under any future state redress scheme and civil claims to identify current staff in government institutions or carers in the out of home care system who are the subject of child abuse allegations, including by adding relevant information to the recommended register of misconduct concerning child sexual abuse (Recommendation 20.9)
- g. make appropriate supports available to victim-survivors who disclose abuse at Ashley Youth Detention Centre, including warm referrals, with permission, to sexual assault counsellors who have training and experience in working with victim-survivors of child sexual abuse

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

## 4 Cultural change

In Chapter 11, Case study 1, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. In this section, we examine the organisational culture at the Centre that may have contributed to this abuse. We also describe the significant cultural change that is needed to protect children and young people in detention against the risks of child sexual abuse. As noted in Chapter 3, ‘organisational culture’ consists of the ‘assumptions, values and beliefs, and norms that distinguish appropriate from inappropriate attitudes and behaviours in an organisation’.<sup>134</sup>

We heard that the problems with the culture at Ashley Youth Detention Centre were profound—they are evident in every case study in this volume. We summarise them in Section 4.2. These problems are not new—they have been brought to the Department’s attention on numerous occasions. Despite this, we heard that there is still a need for effective cultural change at Ashley Youth Detention Centre.

As discussed in Chapter 18, the Child and Youth Safe Organisations Act requires that Child and Youth Safe Standards be implemented in institutions engaged in child-related work, including youth detention.<sup>135</sup> These standards require, among other things:

- child safety and wellbeing to be ‘embedded in organisational leadership, governance and culture’ in detention<sup>136</sup>
- children and young people in detention to participate in decisions affecting them and to be taken seriously<sup>137</sup>
- staff in detention to be ‘equipped with the knowledge, skills and awareness to keep children and young people safe’.<sup>138</sup>

Full implementation of the Child and Youth Safe Standards and the creation of a child safe culture in youth detention will require a transformation of the culture into one that respects children’s dignity and human rights, and prioritises child safety. Such a transformation cannot occur without changes to the foundations of the youth detention system. As a former Deputy Secretary of Children and Youth Services told us, the problems in youth detention will not be solved ‘unless you address the culture, the context, the skills and capabilities, the experience and the knowledge base of the staff’.<sup>139</sup>

We acknowledge that cultural change in detention is a monumental and complex challenge and will take time—experts told us it could take five to 10 years.<sup>140</sup> However, it is crucial to ensuring children in detention are safe from ill-treatment and abuse.

Many of the recommendations in other sections of this chapter will support cultural change in detention. However, in this section, we focus on the key areas of leadership, governance, children’s empowerment, children’s participation, staffing, and standards of professional conduct. In particular, we recommend measures to:

- strengthen leadership in the youth detention system
- improve governance arrangements for youth detention, including establishing means to ensure accountability for cultural change
- strengthen children and young people’s participation in detention, including establishing a new advisory group of children, young people and young adults with previous experience of detention
- ensure youth workers are appropriately qualified, trained and supported to deliver a therapeutic model of care to children and young people in detention, with enough staff to keep youth workers, children and young people safe
- establish a professional conduct policy for all people working in detention facilities that specifies expected standards of behaviour.

Before turning to the evidence of cultural problems in Ashley Youth Detention Centre and our recommendations for change, we outline the specific cultural factors that can heighten the risks of child sexual abuse and ill-treatment in detention environments.

## 4.1 Identifying and addressing cultural risk factors in youth detention

As discussed in Chapter 3, child sexual abuse can occur in any institution, but some institutional contexts and cultures enable sexual abuse.<sup>141</sup> ‘Closed’ or ‘total’ institutions such as youth detention—which exercise full control over a child’s day-to-day life and where children are isolated from the outside world and depend entirely on the institution—‘present a high cumulative risk of child sexual abuse’.<sup>142</sup> This is, in large part, due to cultural risk factors in youth detention.

As outlined in Chapter 10, the National Royal Commission identified the cultural characteristics of contemporary detention environments that may increase the risk of child sexual abuse.<sup>143</sup> These included:

- failing to prioritise children’s welfare and wellbeing<sup>144</sup>
- failing to give children the opportunity to communicate their views—this reflects a culture in which children are not listened to and their views are not respected<sup>145</sup>

- disrespecting children—where children are seen as ‘less worthy’, staff may show discriminatory attitudes towards them<sup>146</sup>
- tolerating humiliating and degrading treatment of children—‘[w]hen children are dehumanised, staff can become desensitised to children’s needs, and cease seeing them as children in need of care and protection’<sup>147</sup>
- engendering a strong sense of group allegiance among staff—children are less likely to disclose abuse and less likely to be believed in institutions with strong group allegiance between adults.<sup>148</sup>

Also, cultural norms not to speak out or ‘snitch’ decrease the likelihood of children making complaints, particularly where they are experiencing harm caused by another child or young person in detention.<sup>149</sup>

Some of these characteristics echo those identified in a 2015 paper on institutional culture in detention prepared by Penal Reform International, an international non-government organisation, as a resource tool for bodies that monitor places of detention.<sup>150</sup> That paper identified aspects of culture in detention facilities that constitute risk factors for torture and other ill-treatment of detainees.<sup>151</sup> These factors include:

- the view that people deprived of liberty don’t deserve rights
- the loss of the detained person’s status as an individual
- the view that security is paramount
- a culture of violence
- an ‘us and them’ attitude between staff and detainees
- a culture of impunity, where there is a general tolerance of human rights abuses.<sup>152</sup>

The case studies in this volume indicate that many of these characteristics have been present at Ashley Youth Detention Centre.

The 2015 Penal Reform International paper listed the components of ‘human rights culture change’ in places of detention, defined as ‘the process of moving an organisation to be more inclusive and to fully respect and accommodate the dignity, worth and rights of all people’.<sup>153</sup> These were:

- implementing change through participatory processes involving staff, detainees and (where appropriate) members of the community<sup>154</sup>
- ensuring leaders are committed to change<sup>155</sup>
- articulating and communicating a new organisational vision statement or management philosophy that is people-centred and based on human rights principles<sup>156</sup>

- adjusting the operational structure of the detaining organisation to ensure appropriate responsibility and accountability for the detention system<sup>157</sup>
- updating policies and procedures to reflect the wider purpose of the organisation and human rights principles<sup>158</sup>
- implementing a ‘dynamic security’ approach that recognises that ‘positive staff-prisoner relationships combined with fair treatment and positive activities’ enhance security and good order<sup>159</sup>
- changing symbols and language, where there is a need to break with the past—this could include changing the name of an organisation<sup>160</sup>
- improving the physical environment to support the implementation of human rights<sup>161</sup>
- recruiting staff whose skills and experience ‘reflect the values, policies, new operational structures and roles’ of the organisation and ‘dismissing staff who are not suitable for the role or new organisation’<sup>162</sup>
- training staff to ensure they understand the new vision, policies and procedures<sup>163</sup>
- ensuring adequate supervision of staff and reinforcement of changes<sup>164</sup>
- addressing resistance and ‘emphasis[ing] that a human rights culture will be better for everyone’.<sup>165</sup>

Several of these components are addressed by recommendations in other sections of this chapter. For example, in Section 6, we discuss the physical environment of detention facilities, the relationship between operational staff and children and young people, and implementing a therapeutic model of care in youth detention. In this section, we recommend changes that address the remaining components identified here.

Professor Donald Palmer, an expert on the causes, processes and consequences of wrongdoing in organisations, told us that cultural change to support implementing child safe policies and procedures can be hard to achieve. He said that it:

... requires that attention be given to the complex process through which members of an organisation come to embrace ... assumptions about the way the world operates, values and beliefs about what is good and bad, and norms about how people should think and act.<sup>166</sup>

According to sociologist Dr Samantha Cromptoets, organisational change requires examining power within organisational structures:<sup>167</sup>

This means understanding how power operates within different levels of the organisation, asking who and what has power, and how does power shape, influence, and obstruct change. To enact organisational change, you cannot rely on the tools, mechanisms and structures already in practice that have been used to oppress the powerless. Organisational structures are comparable to the

scaffolding which holds cultures of misconduct and existing power structures in place. To change culture, you need to change the rules that dictate the distribution of power.<sup>168</sup>

## 4.2 The culture at Ashley Youth Detention Centre

The following discussion identifies problems with the culture at Ashley Youth Detention Centre, including concerns expressed about operational staff. It is important to acknowledge that youth workers at Ashley Youth Detention Centre work in an extremely challenging environment. Many youth workers are deeply committed to supporting the wellbeing of children and young people in detention, many of whom have highly complex needs and challenging behaviours. The following discussion is not intended as a criticism of these youth workers.

### 4.2.1 Past reviews and recommendations

As noted in Chapter 10, the evidence and material available to our Commission of Inquiry included 17 reports, internal and external reviews and briefings about Ashley Youth Detention Centre since 2003. Many of these documents identified problems with the culture and/or staffing at the Centre.

In summary, we are aware of the following concerns that have previously been raised about the culture at Ashley Youth Detention Centre:

- In 2007, a Legislative Council Select Committee examining the youth justice system and longstanding problems at Ashley Youth Detention Centre found that management ‘struggle[d] to maintain a well-trained, professional, and committed staff’ and that ‘from time to time there [were] violent aggressive episodes involving both residents and staff’.<sup>169</sup> The committee made 32 recommendations. These included addressing the ‘continuing low morale’ among staff at Ashley Youth Detention Centre.<sup>170</sup>
- In 2011, the Serious Incident Investigation Committee, established by the former Department of Health and Human Services to examine the circumstances of the death of a young person at Ashley Youth Detention Centre, found that: youth workers at the Centre were unprofessional; not all staff had completed the induction program; there was no ongoing culture of education and training; and the training provided to staff was inadequate for responding to critical incidents.<sup>171</sup> The committee also found that while there had been some changes to recruitment processes, ‘there [was] a strong likelihood the pervading cultural norms and practices may be undermining this’ change.<sup>172</sup> The committee recommended that the youth worker role be reviewed and that immediate action be taken to address concerns about the culture at the Centre.<sup>173</sup>

- In 2015, an independent review of Ashley Youth Detention Centre found that its culture leaned more towards punishment than restoration and rehabilitation, with a preference for using force to manage children and young people rather than the de-escalation techniques taught in training.<sup>174</sup> The review commented on the long tenure of staff and referred to a culture of ‘passive resistance’ to change and a lack of visibility and communication from leadership and senior management.<sup>175</sup> The review made 13 recommendations, including recommendations aimed at improving leadership and training.<sup>176</sup>
- In 2016, an options paper on potential custodial youth justice models prepared by Noetic Solutions noted that some staff at Ashley Youth Detention Centre were sceptical of a therapeutic approach to managing young people in detention.<sup>177</sup>
- In 2016, a ‘Minute’ prepared by a senior employee of the former Department of Health and Human Services for Secretary Pervan referred to the ‘negative culture’ at Ashley Youth Detention Centre, attributable to multiple reviews of the Centre, uncertainty surrounding its future, an ‘outdated understanding or lack of understanding from some staff that [sub]scribe to a punitive approach in dealing with young people’ and ‘a historical lack of transparent practice’.<sup>178</sup> The Minute also identified concerns about governance, leadership, staffing capability and compliance with legislation and human rights obligations and indicated that issues had remained ‘embedded’ at the Centre ‘for a significant period’.<sup>179</sup> The Minute noted that a significant number of staff had been at the Centre for many years and recommended a ‘significant change management process’, including ‘profiling of the required skill base ... in order to establish staffing needs for the future’.<sup>180</sup> This Minute is discussed at length in Chapter 11, Case study 3.
- In 2016, a report prepared by the former Department of Health and Human Services to the then Minister for Human Services about violent incidents at Ashley Youth Detention Centre noted an apparent excessive use of force by a youth worker and made several recommendations, including appointing a senior change manager and developing a proposal to strengthen the use of multidisciplinary teams to support a therapeutic approach.<sup>181</sup> This report is discussed in detail in Chapter 11, Case study 4.
- In 2019, the Ombudsman submitted a report to Secretary Pervan after receiving a complaint about excessive use of force by staff at Ashley Youth Detention Centre against a young person in December 2017. In this report, the Ombudsman noted that ‘the training and the transition over recent years from a corrections focus to a rehabilitation and therapeutic focus [were] often at odds and despite significant training some staff continue[d] to operate from a corrections philosophy’.<sup>182</sup>



- In 2020, the former Department of Communities' Serious Events Review Team identified 'a toxic workplace culture at [the Centre] characterised by distrust, suspicion, conflict, and frustration'.<sup>183</sup> The review made 17 recommendations, including training and developing a strategy to address workplace culture 'as a matter of urgency'.<sup>184</sup> This review is discussed in Chapter 11, Case study 2.
- In 2020, the Australian Childhood Foundation prepared the *Through the Fence* report, which summarised consultations with a range of stakeholders about developing a trauma-informed operating model for Ashley Youth Detention Centre.<sup>185</sup> Consultations indicated that the Centre's culture was 'risk averse, focussed on containment and punitive in nature'; the operational environment of the Centre was reactive, ad hoc and unsafe for staff and young people; awareness and understanding of the Ashley Youth Detention Centre Model of Care (introduced in 2019) was very low; and support for change among staff was mixed, with a lack of support influenced by past ineffective efforts to facilitate change.<sup>186</sup> The report noted a 'significant paradigm shift' would be required to implement a trauma-informed practice framework in detention.<sup>187</sup>

Despite these reviews and recommendations, meaningful cultural change does not appear to have been achieved. This lack of change is evidenced in the following discussion.

#### 4.2.2 What we heard about the culture in detention

The evidence we heard reflects many of the findings of the earlier reviews outlined in Section 4.2.1.

##### Security as the paramount consideration

Stuart Watson, the previously mentioned Centre Manager, told us that youth workers at Ashley Youth Detention Centre:

... represent a parent-like person who assists the young people to meet their daily goals, including making their beds, cleaning, laundry, pro-social conversation and recreational activities such as playing cards or kicking the football.<sup>188</sup>

By contrast, several other witnesses commented on the primary purpose of the youth worker role appearing to be to maintain security and keep children and young people contained. Mark Morrissey, former Commissioner for Children and Young People, observed that, during his time as Commissioner between 2014 and 2017, youth workers at Ashley Youth Detention Centre seemed to be primarily concerned with the custodial rather than the therapeutic aspects of their role.<sup>189</sup> Mr Morrissey referred to this as a "detention centre" culture.<sup>190</sup>

Professor White, who had extensive exposure to Ashley Youth Detention Centre from 2010 to 2012 as a member of the Serious Incident Investigation Committee (referred to in Section 4.2.1), commented on the inappropriateness of the title ‘youth worker’, given the security focus of the role:

... they were called youth workers but I think ... that’s a euphemism ... the so-called ‘youth workers’ saw their role [as]... basically to provide security and, in their terms security meant ... to make sure that the kids are locked up and that there’s secure movement through the institution ... it’s a misnomer to call them youth workers because the usual sense of the word ‘youth worker’ means it’s a professional youth and community worker who works to support children and to address their immediate needs. This is by no means what we mean by youth worker in the case of Ashley.<sup>191</sup>

Similarly, Mr Morrissey referred to the youth workers as ‘guards’.<sup>192</sup>

These observations are reinforced by the practices of the Department in engaging private security companies to address staff shortages in the recent past.<sup>193</sup>

Madeleine Gardiner, who worked at Ashley Youth Detention Centre until 2019 as Manager, Professional Services and Policy, reflected that the ‘operational need [at Ashley Youth Detention Centre] appeared at times to take priority over the rehabilitation needs of the young people’.<sup>194</sup> She expressed concern that trauma-informed responses and therapeutic practices were not well understood by some operational staff.<sup>195</sup>

We heard that prioritising security over therapeutic practices and trauma-informed responses to children and young people contributed to conflict between operational staff and professional services staff in decision-making forums at Ashley Youth Detention Centre. Ms Gardiner said that ‘differences in professional opinion’ about the care and management of young people at Ashley Youth Detention Centre were often the source of conflict between professional services staff and operational staff.<sup>196</sup> In Ms Gardiner’s opinion, professional services staff operated from a ‘theory and evidence base’, but operational staff ‘came from a practice of, “This is what we’ve always done and this is what we do to ... operate the centre and to keep the centre safe”’.<sup>197</sup>

In Chapter 11, Case study 2, we observe that there was an apparent prioritising of operational concerns over protecting young people from the risk of harmful sexual behaviours. We also observed that the advice of staff, who had knowledge and experience of harmful sexual behaviours and the management of such behaviours, appears not to have been given as much sway as the concerns and views of operational staff.

## **A punitive culture**

The case studies in this volume detail the extensive evidence we heard about alleged abusive practices by staff at Ashley Youth Detention Centre. As discussed in Chapter 11, Case study 1, we heard about a longstanding corrosive staff culture at the Centre

that valued coercive and punitive responses to children and young people, including using force, strip searches and isolation techniques, and enabled abusive practices and human rights violations to occur. Those accounts suggest the culture at the Centre was at odds with a therapeutic model of care that supports trauma-informed responses to the challenging behaviours of children and young people in detention. In Section 6, we make recommendations for implementing such a model of care.

A former manager of Ashley Youth Detention Centre told us that when he first started in his role in the early 2000s, he observed that the Centre worked on a system run by fear and total control by staff and the belief that young people ‘could only be managed through intimidation and coercion’.<sup>198</sup>

Professor White observed that using punishment, segregation and isolation at Ashley Youth Detention Centre was inconsistent with the care, understanding and mentoring that children and young people typically require when they act out.<sup>199</sup> Professor White told us he was particularly struck by ‘the apparent lack of empathy’ some staff showed towards residents, referring to a ‘sense of coldness and indifference’ among those staff.<sup>200</sup>

Professor White further stated:

... there was no sense of a rehabilitation, welfare or restorative mission. The orientation was towards social control and a lock-up mentality, rather than attempting to make institutional conditions that would foster a more pleasant place in which to live and/or provide opportunities for individual betterment.<sup>201</sup>

Dr Michael Guerzoni, Indigenous Fellow—Academic Development, University of Tasmania, an expert in criminology and juvenile justice, told us that he understood the culture at Ashley Youth Detention Centre to be ‘punitive’, describing it as a culture that:

... is informed by a view that the children in their care are bad people who do not deserve to be treated well. These views and assumptions are further strained by the difficulties of working in criminal justice, intensifying the default view of children in this context and contributing to a culture that routinely overlooks and disregards policies and procedures.<sup>202</sup>

Mr Morrissey told us he had observed the ‘heavy handed and excessive’ restraint of children and young people by certain staff when he visited the Centre as Commissioner for Children and Young People.<sup>203</sup> He also described verbal abuse from some staff towards children and young people detained at the Centre:

On several occasions I witnessed incidents of verbal abuse and belittling of the young people by certain staff. I reported these incidents to management however was not advised of the outcome. The custodial staff involved in this abuse remained on staff at [Ashley Youth Detention Centre]. It concerned me that such verbal abuse had become normalised ...<sup>204</sup>

Both Mr Morrissey and Professor White conveyed their astonishment and concern that some staff would engage so openly in poor behaviour towards young people.<sup>205</sup>

Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre from late 2019 to mid-2020, was critical of some staff at the Centre, describing them as ‘highly punitive’ and ‘often verbally abusive, sometimes physically abusive or excessively forceful’ towards children and young people.<sup>206</sup> Alysha recalled ‘many instances of staff going out of their way to humiliate or belittle children’.<sup>207</sup> She said that it seemed to her that staff intended to show young people ‘who was in control’.<sup>208</sup>

Alysha further stated:

I felt like they [staff] ... didn’t respect the children; certainly didn’t have—and again, not all staff, but the majority—I’m confident in saying that the majority did not look to meet their needs, did not care about what they could do to best support individual young people in their rehabilitation, how they could best support them; that wasn’t something that entered the conversation.<sup>209</sup>

Alysha’s impressions of the culture and approach at Ashley Youth Detention Centre largely echoed those of Professor White, despite their experiences at the Centre being several years apart.

Victim-survivors told us about their impressions of youth workers in detention, whom they also called ‘guards’. Simon (a pseudonym), who was detained at Ashley Youth Detention Centre in the early to mid-2000s, said:

I can sit here and tell you right now the guards at Risdon Prison are a lot better than the Ashley Youth Detention Centre ones; they treated people like shit. You shouldn’t be doing that, you know what I mean, they’re children at the end of the day.<sup>210</sup>

Victim-survivor Warren (a pseudonym), who was detained at Ashley Youth Detention Centre in the mid to late 2000s, told us:

Other guards would bring their bad mood to work. If they didn’t like you, they would be physical with you. If you gave them a little bit of lip, they would restrain you and nearly snap your arm behind your back.<sup>211</sup>

These comments are consistent with some of the accounts provided in the context of the research we commissioned to understand how children and young people perceived safety in institutional contexts, including youth detention.<sup>212</sup> Some young people spoke about being assaulted by staff members, often in the context of being restrained or after a critical incident.<sup>213</sup> These accounts are discussed in Chapter 10.

### **Inconsistent treatment of children and young people**

An anonymous professional who worked at Ashley Youth Detention Centre from the mid to late 2010s told us that the Centre’s Behaviour Development System, which assigned colour ratings to children and young people based on their behaviour, was at times misused by staff. They observed that staff ‘favoured’ some young people, with ratings

assigned accordingly.<sup>214</sup> They also observed that the nature of a young person's offending or alleged offending often affected how incidents at the Centre were reviewed and ratings assigned—'a young person on rape charges at times was treated more harshly because staff didn't like the charges'.<sup>215</sup>

Similarly, Ms Gardiner told us she 'was aware that young people felt that some staff were harsher or more lenient on some detainees than others' in relation to the Behaviour Development System.<sup>216</sup> In Chapter 11, Case study 3, we discuss how, at times, the 'Blue Program', once a part of the Behaviour Development System, would have resulted in some children experiencing isolation practices as punishment. We discuss the Behaviour Development System and its later iteration, the Behaviour Development Program, in Section 6.3.

### **Socialisation of new staff into a longstanding culture**

As discussed in Chapter 11, Case study 1, the longstanding tenure of many staff at Ashley Youth Detention Centre contributed to entrenching problematic attitudes and normalising the poor treatment of children and young people. Dr Guerzoni told us he understood that 'the evidence suggests that new workers at Ashley Youth Detention Centre have been socialised into a punitive culture'.<sup>217</sup>

Mr Morrissey told us that, during his time as Commissioner for Children and Young People, new staff regularly entered Ashley Youth Detention Centre with energy and positive ideas, but were overwhelmed by the existing and longstanding culture:

... I think they often had a choice of adopting the prevailing longstanding culture or moving on. It was a very—culture, as we know, is very critical, but the culture at Ashley was a very powerful culture that was very difficult for just a few people to overcome and change ...<sup>218</sup>

Similarly, victim-survivor Max (a pseudonym), who was detained at the Centre for periods from the late 2010s to the early 2020s, told us that even if a youth worker started with positive intentions, they would soon be socialised into the dominant culture at Ashley Youth Detention Centre:

Like, the new ones, the new ones that they've brought, like, what I seen is, like, I don't know what they're like now, but after being there a year and that, they normally turn into the same as the other ones ... Yeah, it was the best thing when a new one started because they were actually nice and they never used to do any of that, and the youth workers would gradually ease them into it, like, they'd sort of ease them into showing them all this stuff.<sup>219</sup>

In Chapter 11, Case study 1, we find that some staff likely felt peer pressure to conform to the poor practices of others (for example, in relation to strip searching) and took part reluctantly on this basis but, also, to avoid becoming targets for abusive or bullying behaviour from colleagues (refer to the following discussion). We consider that some of this behaviour reflects a highly traumatised and dysfunctional workforce.

## Bullying and unprofessional behaviour

We heard evidence of bullying and unprofessional behaviour among staff at Ashley Youth Detention Centre. Fiona Atkins, Assistant Manager at the Centre, agreed with a suggestion put to her by Counsel Assisting our Inquiry that there was a ‘top-down command and control culture of management’ at the Centre in 2019 when she was in operations and training roles.<sup>220</sup> She also said that she had personally been subjected to ‘bullying behaviours’ by some of the management group around this time.<sup>221</sup>

Mr Watson, who began in the role of Assistant Manager at the Centre in early 2020, told us about difficulties he experienced with a colleague.<sup>222</sup> He explained:

[The colleague] didn’t vacate the office for, I think it was four days, and when they did vacate the office they left it really dirty and grotty, and a voodoo doll hanging from the monitor with pins through the heart of the voodoo doll. I was also informed by staff up there that it was [the colleague’s] belief that they could drive me out and then they could assume the position of Assistant Manager, and that that was their intention.<sup>223</sup>

Mr Watson also stated that, when he started as Assistant Manager, staff felt ‘unsafe’, ‘oppressed’ and ‘bullied’ by members of the management group and people were generally scared to speak up to that group at that time.<sup>224</sup>

Similarly, Veronica Burton, a former Serious Events Review Team reviewer, told us that staff felt ‘very intimidated to raise issues’ with this management group.<sup>225</sup>

They described incidences of verbal abuse, being yelled at, being physically assaulted on a couple of occasions by being pushed, and prevented from leaving a room, and being spoken over the top of in meetings when they tried to express concerns about decisions that were being made in meetings.<sup>226</sup>

Alysha told us that, during meetings of the Centre Support Team (a decision-making forum discussed in Chapter 10 and Section 6.4), some staff engaged in ‘voice raising, swearing, name calling, silencing, excluding, speaking over, belittling, eye rolling, finger pointing or other intimidating gestures’, usually aiming such behaviours at professional services staff.<sup>227</sup>

A former Manager, Professional Services and Policy (not Ms Gardiner) told us that some staff, particularly those recruited many years ago, were ‘not restrained and guided by professional value sets’.<sup>228</sup> Ms Burton described an interaction with a staff member who told her that he had made a comment to some young people in detention about their genitals.<sup>229</sup> Ms Burton said she was ‘taken aback’ because:

... it’s not a professional comment to make, it’s not a way that you would talk to another professional from an external service reviewing, you know, the Centre; it just seemed at the very least inappropriate and uncomfortable. And at the worst, I guess, it felt uncomfortable that he would be talking about the boys’ genitals and joking about that.<sup>230</sup>

## Resistance to change

Mr Morrissey said the prevailing culture at Ashley Youth Detention Centre had remained unchanged for decades.<sup>231</sup> He referred to a ‘static institutional culture that was by its very nature unable to be forward thinking or offer therapeutic care that was in the best interests of children’.<sup>232</sup>

The unchanged culture at Ashley Youth Detention Centre may have been related to the lengthy service of some staff members, which we discuss in several case studies in Chapter 11. We heard that several current staff have been working at Ashley Youth Detention Centre since the early 2000s.<sup>233</sup>

The entrenched culture may also have been reinforced by the fact that many of the staff at the Centre were drawn from the local community, where they were connected through sporting and social clubs.<sup>234</sup> As Professor Richard Eccleston, University of Tasmania, stated, strong social and professional connections can result in interdependencies that ‘make it particularly difficult to maintain integrity and a commitment to process and ethical conduct’.<sup>235</sup> In Chapter 11, Case study 1, we find that familial and personal connections between some staff created strong social disincentives to challenge, question or report poor behaviour of staff towards children and young people.

Victim-survivor Erin (a pseudonym) commented on this dynamic:

I would describe the staff at Ashley as being like a pack of animals. Some of them had been working there for 30 years. They all went to school together. They were all from [the local area], which was a small country town. They all looked after each other.<sup>236</sup>

Alysha expressed the view that ongoing failures to implement therapeutic approaches to managing children and young people at Ashley Youth Detention Centre were, in part, due to a general unwillingness among most staff to ‘consider new approaches’ and to change the way in which the Centre operated.<sup>237</sup>

Similarly, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, who authored the *Through the Fence* report (discussed in Section 4.2.1), referred to the absence of an ‘authorising environment’ to ‘try to do things differently’ at Ashley Youth Detention Centre.<sup>238</sup> She also referred to a lack of ‘unity of vision’ among some staff:<sup>239</sup>

There are the ‘old guard’ as some would call them, and then there’s the new guard. There’s people who are more up for giving something different a go, and then there’s the dyed in the wool, ‘This is the way we’ve always done it, this is the way I’m going to keep doing it, this is what’s going to make a difference’...<sup>240</sup>

Mandy Clarke, former Deputy Secretary, Children, Youth and Families in the former Department of Communities, told us the attitudes and practices of staff at Ashley Youth Detention Centre may be difficult to shift:



It is possible that [staff] may at times refer to stories of the old days which could be an ongoing challenge for the Centre management in their efforts to redefine a workplace culture characterised by therapeutic practice approaches.<sup>241</sup>

Secretary Pervan conceded that departmental leadership did not understand the extent of cultural issues at Ashley Youth Detention Centre and acknowledged some staff members' resistance to change:

In retrospect, those cultural issues are far harder to change ... I think myself personally didn't understand the depth and strength of, if not the culture of the institution, the culture around a group of individuals and their resistance to change.<sup>242</sup>

### **Staffing challenges and an unsafe environment for youth workers**

As discussed in Chapter 10, longstanding systemic challenges related to staffing at Ashley Youth Detention Centre appear to have contributed to the persistent problems in the culture and in the treatment of children detained there. These challenges include difficulties in fully staffing the Centre due to resourcing, staff turnover and unplanned staff absences, and difficulties attracting, retaining and training an appropriately skilled and qualified workforce to work at the Centre. These challenges have also contributed to creating an unsafe work environment for youth workers, which in turn risks the safety of children and young people.

We received statements from current and former Ashley Youth Detention Centre employees that tell a story of staff trying to do their best in highly challenging operational circumstances. Several staff members told us that on-the-job training was haphazard, poorly attended and did not equip staff to effectively respond to workplace incidents. Sarah Spencer, a youth worker at Ashley Youth Detention Centre since 2011, provided evidence to us in August 2022. She told us:

Staff are assaulted on site regularly, consistently ... We're trying to get more staff: we're not supported. We don't get debriefings after critical incidents, we don't get breaks as I've already said. We do not get clinical supervision ... We've got inexperienced staff who are not trained properly, who are only going to make more mistakes, and then it's going to be their fault again, and it shouldn't be.<sup>243</sup>

Ms Spencer added: 'We have not had the support, we have not had the care that we have required or the professional training or the professional supervision or anything that we needed'.<sup>244</sup> Ms Spencer said that she felt caught up in a persistent cycle of trauma at the Centre, which left little time for ensuring young people got the rehabilitative attention they needed to stop them being detained again.<sup>245</sup>

Colleen Ray, a youth worker who has been at Ashley Youth Detention Centre since 2002, told us that there had been ongoing staff shortages at the Centre, particularly in the previous four years, and that a significant cohort of staff worked multiple

overtime shifts each week.<sup>246</sup> Similarly, Ms Spencer said that staff were often required to work long shifts with few or no breaks, to the point where some staff brought spare underwear to work in anticipation of a lack of necessary bathroom breaks.<sup>247</sup>

Ms Spencer told us that implementing restrictive practices (lockdowns) at the Centre due to staff shortages meant that when young people were eventually released from their rooms or units, they were considerably more difficult to manage, which created more risks to the safety of staff:

Well, when you're working with staff who can't restrain aggressive young people, who at the moment due to the fact that we're in restricted practices, so rolling lockdowns because we don't have the staff, when they do come out, obviously they're heightened, and we get that, but we can't—the few people that were managing them couldn't manage them, and so, the whole shift was just horrific ...<sup>248</sup>

In Chapter 11, Case study 1, we find that the highly pressured, stressful and occasionally frightening conditions in which staff sometimes had to work, coupled with inadequate training and professional development for some staff, made it more likely for staff to deviate from best practice when seeking to manage the behaviour of children and young people. We also find that difficult behaviours displayed by children and young people likely contributed to staff holding negative attitudes towards them. We consider that this context would facilitate new staff becoming absorbed into an existing punitive culture.

The risks to staff safety at Ashley Youth Detention Centre appear to be ongoing. In a submission to a parliamentary inquiry into adult imprisonment and youth detention in Tasmania in March 2023, a former police officer who worked for several months at Ashley Youth Detention Centre in late 2022 described the Centre as 'an abusive and violent working environment where youth workers ... are subjected to verbal and physical abuse [from young people] daily'.<sup>249</sup> This submission also referred to the prevalence of absenteeism among youth workers and the substantial proportion of youth workers who were suspended or on leave due to workers compensation claims.<sup>250</sup>

We discuss support for staff, staff shortages and a range of other issues related to staffing in Section 4.7.

### **Efforts to address cultural problems at Ashley Youth Detention Centre**

Ms Gardiner said a 'change manager' employed at Ashley Youth Detention Centre in 2018 undertook work to develop a therapeutic approach at the Centre and improve working relationships.<sup>251</sup> According to Ms Gardiner, this work was collaborative, staff were receptive to it and 'there was an energy and an appetite for making some significant improvements in the centre'.<sup>252</sup> However, the change manager role was defunded in June 2018.<sup>253</sup>

Mr Watson expressed the view that the culture at Ashley Youth Detention Centre had changed in recent years:

I believe that at this time at Ashley that [the] culture isn't as it's been suggested. I believe that it has been in the past, but the staff changes over the last two years that I've been there have been incredible. There's very few of the staff that were there when I started now.<sup>254</sup>

In August 2022, Pamela Honan, Director, Strategic Youth Services, told us that the relationship between operational staff and professional services staff had improved, describing it as 'respectful, supportive, collaborative and equal'.<sup>255</sup> Ms Honan attributed the improved relationship to appointing new senior managers in both teams, a 'shift to a more accountable and collaborative style of leadership and decision making' supported by the new *Ashley Youth Detention Centre Practice Framework* (discussed in Section 6.3.3) and increased accountability across all staff for case management, incident reporting and policy compliance.<sup>256</sup> Ms Honan said organisational change didn't 'happen overnight', particularly in the context of 'years and years of a poor culture'.<sup>257</sup> However, she believed positive change had begun.<sup>258</sup>

Similarly, Secretary Pervan told us positive change was already underway at Ashley Youth Detention Centre, although he acknowledged that genuine cultural change would take time:

We're on the way. It'll take a decade before what you've got there is at least a benchmark facility and service, whether it's at Ashley or it's, you know, at the ... new facilities. Changing those cultures are not just about changing people's attitudes; in many respects they're about changing the people themselves.<sup>259</sup>

Given the depth of the cultural problems identified in this section, we consider that more significant reform of the youth detention system is required to achieve meaningful cultural change. This should occur immediately, given the number of past reviews that have shown incremental reform to be ineffective.

### 4.3 The Government's proposed reforms

As noted in Section 2, the Tasmanian Government has announced plans to close Ashley Youth Detention Centre and 'transition to contemporary therapeutic facilities and models of care by the end of 2024'.<sup>260</sup>

The Government's Draft Youth Justice Blueprint, Draft First Action Plan and Keeping Kids Safe Plan each contain proposed reforms that broadly seek to address the cultural problems we have identified.<sup>261</sup> For example:

- A principle underpinning the Draft Youth Justice Blueprint is to 'create a culture that fosters child safety and wellbeing across the youth justice system in Tasmania'.<sup>262</sup>

- An aim of Strategy 5 ('Provide an appropriately trained and supported therapeutic workforce') of the Draft Youth Justice Blueprint is to develop 'an ongoing culture of learning, inquiry and continuous improvement, including collaborative opportunities for professional development, supervision, support; and opportunities for best practice to be shared and supported'.<sup>263</sup>
- The Draft First Action Plan refers to an 'increased culture of safety for staff and children and young people' and 'increased professionalism of [the] workforce' as expected outcomes of Action 1 ('Enhance the safety and therapeutic approach at [Ashley Youth Detention Centre]') and Action 2 ('Develop and implement a Youth Justice Model of Care').<sup>264</sup>
- The Keeping Kids Safe Plan states that the Department for Education, Children and Young People 'will continue to focus on delivering practice improvement, professionalisation of centre operations and the workforce, and importantly, culture change'.<sup>265</sup>

We refer to more specific proposed reforms from these documents throughout this section. We turn now to our recommendations for change.

## 4.4 Strong and active leadership

Strong and active leadership is critical to creating a child safe culture. Leaders should instil a culture that 'inhibits the perpetration of child sexual abuse, speeds the detection of abuse, and enhances the response to abuse'.<sup>266</sup> Professor Palmer stated that leaders 'demonstrate cultural content' in several ways—by the people they hire and fire; the behaviour they reward and punish; the matters they focus on; the way they respond to crises; and the attitudes and behaviours they display.<sup>267</sup>

### 4.4.1 Leadership roles in youth detention

As outlined in Chapter 10, the Secretary of the Department is responsible for the security and management of Ashley Youth Detention Centre and the safe custody and wellbeing of children and young people in detention.<sup>268</sup>

In October 2022, responsibility for youth justice services was transferred from the former Department of Communities to the Department for Education, Children and Young People.<sup>269</sup> Since this restructure, the position of Executive Director, Services for Youth Justice, which was created in August 2022, has been responsible for Ashley Youth Detention Centre and broader youth justice services.<sup>270</sup> Initially, the Executive Director reported directly to the Secretary; however, the Department has advised us that, since the restructure, the Executive Director reports to an 'Associate Secretary'.<sup>271</sup>

The current Executive Director, Services for Youth Justice is Christopher Simcock. In oral evidence, Mr Simcock told us that he has two direct reports—Ms Honan

(Director, Strategic Youth Services, sometimes also referred to as the Director, Youth and Family Violence Services) and the ‘Director of Custodial’.<sup>272</sup> We understand this to be a reference to the Director, Custodial Operations—a new role that has been ‘filled through a secondment from 5 September 2022 for a 12 month period to focus on additional staff and operational support at [Ashley Youth Detention Centre]’.<sup>273</sup>

We understand that, since the October 2022 restructure, the Manager, Custodial Youth Justice (‘Centre Manager’), who is based at Ashley Youth Detention Centre, continues to report to the Director, Strategic Youth Services. The Centre Manager is responsible for managing the day-to-day operations of Ashley Youth Detention Centre, the development and leadership of a management team, and providing direction for programs at the Centre.<sup>274</sup> As at May 2022, the Centre Manager role was a Band 8 in the Tasmanian State Service and had four direct reports.<sup>275</sup>

#### 4.4.2 Strengthening leadership

A paradigm shift is required in youth detention in Tasmania to move from a punitive, custodial model to a therapeutic model of care. The Government has outlined a major youth justice reform agenda for the next 10 years, including reviewing the Youth Justice Act, closing Ashley Youth Detention Centre and building new youth justice facilities. Effective and timely implementation of these measures will require active, expert and decisive leaders who are committed to achieving the necessary cultural change to support reform and create a child safe culture in detention.

Adjunct Associate Professor Mitchell stressed the importance of committed leadership in changing an entrenched culture:

Leadership sets the environment within which the work happens. So, if you don’t have leadership that is on board with what you’re trying to achieve operationally, then you are doomed to fail.<sup>276</sup>

Ms Clarke told us that ‘very, very strong leadership’ was necessary to implement a therapeutic practice framework in youth detention and that such leadership ‘must be grounded in understanding and an absolute commitment to therapeutic practice’.<sup>277</sup> Similarly, Ms Burton indicated that leadership in implementing a therapeutic framework in detention was crucial:

... it needs to be a top-down approach to change, otherwise the barriers will remain. If the framework, whatever it ends up being, and the therapeutic service is not embraced by executive, it won’t be successful.<sup>278</sup>

Objective 2 of the Keeping Kids Safe Plan refers to developing a Youth Justice Services Workforce Strategy (discussed in Section 4.7.2) with ‘a strong leadership focus’.<sup>279</sup> The plan also refers to establishing several new leadership positions ‘to manage specific areas’ at Ashley Youth Detention Centre, including Director, Custodial Operations (referred to in Section 4.4.1); Director, Clinical Services; Assistant Manager,

Case Management; and Assistant Manager, Security, Risk, Training and Audit.<sup>280</sup>

We are pleased to see these new leadership roles being introduced. We are unclear whether these roles will be located at the Centre or the Department or both, noting that strong leadership will be necessary in both the Department and Ashley Youth Detention Centre (and any future detention facility).

As noted in Section 4.4.1, the Executive Director, Services for Youth Justice reports to an Associate Secretary, who reports to the Secretary.<sup>281</sup> The Associate Secretary's three other direct reports are Deputy Secretaries.<sup>282</sup> We are concerned about this lack of parity in seniority among the leaders in the Department. In such a large department, it is vital that the youth justice leader has enough seniority to represent the significant risk carried by that portfolio involving Tasmania's most vulnerable children. However, we acknowledge that in a small jurisdiction such as Tasmania it may not be feasible to elevate this role to that of a Deputy Secretary.

At a minimum, we consider that the Executive Director, Services for Youth Justice must have knowledge and understanding of youth justice and therapeutic models of care in youth justice, as well as experience in providing strategic direction and leadership. This is essential to achieving meaningful cultural change in youth detention.

The Executive Director should be an active leader who frequently visits detention and other youth justice facilities to ensure they are aware of and understand the risks to children and young people in those facilities, and are accountable for addressing those risks.

The Executive Director should also be responsible for cultural change at Ashley Youth Detention Centre. Cultural change in youth detention should be included in the Executive Director's key performance indicators and in those of the Associate Secretary and Secretary. We discuss governance arrangements in Section 4.5.

Also, we consider that the role of Centre Manager should be more senior than it currently is, reflecting the complexity and expectations of the role. As noted, detention is a highly complex and challenging environment. The Centre Manager's operational responsibilities for the day-to-day care, supervision and safety of children and young people in detention—many of whom have extremely complex needs—as well as for the safety and supervision of staff, are significant. The current classification of this role does not adequately reflect these responsibilities or the risks associated with them. We recommend a reclassification of this role to accurately reflect its responsibilities.

We also recommend that the Centre Manager's position description and performance measures include implementing cultural change in youth detention.

## Recommendation 12.6

The Department for Education, Children and Young People should:

- a. have appropriate processes in place to ensure leaders in youth detention have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation
- b. ensure the person who holds the position of Executive Director, Services for Youth Justice, has knowledge and understanding of youth justice and therapeutic models of care in youth justice, and experience in providing strategic direction and leadership
- c. ensure cultural change in youth detention is included in the key performance indicators of the Secretary, Associate Secretary and Executive Director, Services for Youth Justice
- d. reclassify the position of Manager, Custodial Youth Justice from Band 8 in the Tasmanian State Service Award to at least a Senior Executive Service Level 1
- e. ensure the position description and performance measures for the role of Manager, Custodial Youth Justice include implementing cultural change in youth detention.

## 4.5 Governance

Good governance is essential to creating a child safe culture in youth detention. As discussed in Chapter 9, the National Royal Commission defined ‘governance’ as ‘encompass[ing] the systems, structures and policies that control the way an institution operates, and the mechanism by which the institution, and its people, can be held to account’.<sup>283</sup>

We consider that good governance for youth detention requires senior leadership to be aware of what is occurring in detention facilities and to be accountable for addressing risks to children and young people in detention. This, in turn, requires transparency from the facility’s management and a clear understanding of what information should be escalated to whom and in what circumstances, particularly about adverse incidents in detention and the use of isolation, force, restraints and searches.

Good governance also requires structures and systems to enable monitoring and evaluation of progress towards clear goals for cultural change and broader system reform.<sup>284</sup> Professor White referred to the importance of monitoring reforms, stating:

... you can have a whole bank of new standard operating procedures, but if you don’t do your monitoring and auditing, then they can just be ignored like the previous ones were.<sup>285</sup>



Dr Cromptvoets highlighted the need for ‘tangible accountability’—for a particular role holder with ‘skin in the game’ to be ultimately responsible for implementing change.<sup>286</sup>

We asked Secretary Pervan to describe the Department’s governance arrangements for Ashley Youth Detention Centre. He told us that:

- Senior executives in the Department undertake ‘[a]dministrative, managerial and operational oversight’ of the Centre.<sup>287</sup>
- The Custodial Inspector and the Commissioner for Children and Young People provide external oversight.<sup>288</sup>
- ‘Additional “external” resources may be provided for the review of significant incidents’, including activating a Serious Events Review Team to undertake an investigation when a child or young person has experienced a ‘serious event’ (death, serious injury or a ‘near miss’ event).<sup>289</sup> The findings of a Serious Events Review Team would be provided to a ‘multi-disciplinary panel of clinical and practice experts’—the Serious Events Review Committee—which includes members from external agencies and advises the Secretary on system-wide recommendations.<sup>290</sup>

We discuss external oversight in Section 11 and the Department’s responses to critical incidents in detention in Section 10. In those sections, we make recommendations to strengthen independent oversight of youth detention and to improve departmental responses to allegations of child sexual abuse and other serious incidents in detention. In Section 9, we consider how certain incidents are reported in the Department.

Here, we discuss managerial and operational oversight of Ashley Youth Detention Centre by senior executives in the Department and mechanisms for monitoring cultural change and system reform.

#### **4.5.1 A lack of transparency**

Counsel Assisting our Inquiry asked Secretary Pervan how he satisfied himself that his delegates were exercising the powers delegated to them appropriately.<sup>291</sup> In his answer, Secretary Pervan referred to two processes—‘the reporting line through the Deputy Secretary down to the Director and their reports back to me’ and ‘that assumption of competence and trust going down the line to exercise those delegations in accordance with the policies that are set for the relative power’.<sup>292</sup>

These processes rely on appropriate reporting by the facility to the Department, so relevant information about the facility can be conveyed to the executive. We heard that this has not always occurred. Ms Honan told us that the relationship between Ashley Youth Detention Centre management and the Department was ‘pretty guarded’ when she took up her role in 2019.<sup>293</sup> She described a closed culture at the Centre:

I felt that ... the Centre operated as a satellite ... it was very inward facing; there wasn't a lot of connection with, not just the department, but other services in the community. It was very closed, very wary, and defensive, I would say ...<sup>294</sup>

Ms Honan also referred to a lack of trust and transparency in reporting by the Centre Manager to the Department (and external oversight bodies):

My impression was that there was also a high degree of mistrust and selectivity in what and how information was reported by the Manager up to the executive to ensure the operating of the centre was positively regarded. The relationship with independent statutory bodies appeared to be wary and uncooperative.<sup>295</sup>

Ms Clarke agreed with these assessments.<sup>296</sup>

In her statement to our Inquiry in August 2022, Ms Honan indicated that transparency at Ashley Youth Detention Centre had improved significantly since 2020 due to a range of measures.<sup>297</sup> These include:

- improved recording and reporting of information to the executive—Ms Honan told us she received 'monthly reports pertaining to searches, restraint, isolation or use of force'<sup>298</sup>
- improvements in incident reporting and the recording of information in isolation, restraint and search registers and in case notes—incidents are escalated to the Department if they involve injury or harm to a child or young person or 'if there is a significant event such as sexual/physical assault, damage to property, disturbance, self-harm, escape'<sup>299</sup>
- 'open and transparent reflection and review of incident management to continuously improve and support best practice'<sup>300</sup>
- the development and implementation of the *Ashley Youth Detention Centre Practice Framework*<sup>301</sup>
- weekly visits by Ms Honan to the Centre, during which she speaks and listens to staff and children and young people<sup>302</sup>
- appointment of a 'Senior Business Partner' (we did not receive more information about this role)<sup>303</sup>
- 'considerable investment in building staff (including managers') understanding and application of the Agenc[y's] values and expected workplace behaviours'.<sup>304</sup>

During the hearings, Ms Honan conceded that other, more significant improvements were needed to fully address the problems at Ashley Youth Detention Centre:

The changes we have put in place are still to some degree not enough. The entirety of reform that needs to happen for Ashley is systems reform. So, what we have managed to do is be more accountable, more transparent, increase the level of

safety around children ... there are more CCTV cameras, there are better practices, I think people feel more comfortable in discussing things that they have concerns about as opposed to them being suppressed ... there is more collaboration around decision making. All of those things help to reduce risk, but they are certainly not reform on the scale that needs to occur.<sup>305</sup>

We welcome the changes that have been implemented at Ashley Youth Detention Centre to improve reporting to the Department, transparency and accountability. However, we agree with Ms Honan that more improvements are needed to bring about meaningful cultural change in youth detention and create an environment that is safe for children and young people and staff.

The Keeping Kids Safe Plan refers to the Department establishing an 'Incident Review Committee' at Ashley Youth Detention Centre in September 2022 to 'review incidents on a weekly basis for compliance with policy and procedure, follow up actions based on review findings and to identify learning areas to support staff'.<sup>306</sup> This committee is chaired by the Director, Custodial Operations, and its members include the Director, Youth and Family Violence Services and the Centre Manager.<sup>307</sup> We discuss this committee in Section 9.3.4.

#### 4.5.2 Monitoring of youth justice reforms

The Tasmanian Government has developed a Youth Justice Reform Governance Framework to support youth justice reform in Tasmania.<sup>308</sup> This framework 'recognises [that] a transformed youth justice system requires a whole-of-government, all of service system, and whole-of-community approach'.<sup>309</sup> The governance framework comprises:

- the 'Children, Young People and Families Safety and Wellbeing Cabinet Sub Committee', whose role is to oversee the development and implementation of the Youth Justice Blueprint (among other matters)<sup>310</sup>
- the 'Youth Justice Reform Steering Committee', comprising Secretaries and/or Deputy Secretaries of all relevant departments—the role of this committee is to provide advice to the Cabinet Sub Committee and the Youth Justice Reform Project Team<sup>311</sup>
- the multidisciplinary 'Youth Justice Expert Advisory Panel', whose role is to provide advice to the Youth Justice Reform Steering Committee on the transition to a therapeutic model and the development of new custodial facilities in Tasmania, and whose members include representatives of relevant departments and non-government organisations—this panel 'has expertise in key areas relating to youth justice services, child and adolescent development, psychological research, child rights, education, trauma and abuse'<sup>312</sup>

- the ‘Youth Justice Blueprint Community Consultative Working Group’, whose role is to provide advice on implementing the Youth Justice Blueprint and to ‘[a]ssist the Tasmanian Government in monitoring the implementation of the Blueprint and Youth Justice Reform in the community’—members of this group include representatives of ‘key youth at risk/youth justice community service organisations and stakeholders’.<sup>313</sup>

Also, as noted in Section 2.1, the Keeping Kids Safe Plan states that a ‘Working Group’ has been established to oversee and monitor that plan’s implementation.<sup>314</sup> The plan does not specify the membership of this group, nor does it explain the relationship between this group and the governance framework outlined here.

According to the Draft Youth Justice Blueprint, a ‘Blueprint Monitoring and Evaluation Plan’ will be developed to measure progress ‘against the intent of the Blueprint and short and long term outcomes across each of the five strategies’.<sup>315</sup> Annual reports will be released providing information on implementation and the effectiveness of actions.<sup>316</sup> Also, the Government’s Draft First Action Plan refers to an ‘Outcomes Framework that will increase our ability to track, monitor and report change over the life of the Blueprint’.<sup>317</sup>

The Draft Youth Justice Blueprint states that some of the indicators of its success will include diversion of children and young people from the criminal justice system and completion of appropriate professional development by staff working in the youth justice system ‘to ensure a children and young person centred, therapeutic and trauma informed response to youth offending’.<sup>318</sup>

It appears that these governance structures will not continue beyond implementing the youth justice reforms. In our view, ongoing governance structures to monitor the performance and culture of Ashley Youth Detention Centre and any future youth detention facilities are essential.

### 4.5.3 Accountability for cultural change

Given the history of cultural problems at Ashley Youth Detention Centre, and the continuing need for change in detention to create a child safe culture, we consider that measures are needed to monitor cultural change and to ensure leaders are accountable for change.

In particular, we recommend that the planned monitoring and evaluation of implementation of the Government’s youth justice reforms specifically include monitoring and evaluation of cultural change in detention. As part of the proposed Outcomes Framework under the Draft Youth Justice Blueprint, objective metrics should be identified or developed to measure cultural change. These should include measures relating to adverse incidents in detention (such as assaults and self-harm), staff absences, workers compensation claims, sick leave, staff retention and grievance procedures.

Self-reporting measures such as staff surveys should also be included, but these should not be the sole measures of cultural change, given previously identified barriers to the reporting of concerns in detention. We also recommend that information from exit interviews conducted by independent community visitors with children and young people leaving detention should be used to measure cultural change (refer to Section 11.4 for a discussion of independent community visitors).

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

The Centre Manager (and the manager of any future detention facility) should be responsible for driving cultural change in detention and ensuring the environment is safe for children and staff. However, we consider that a position based at Ashley Youth Detention Centre to assist the Centre Manager in this function would be beneficial. As noted in Section 4.2.2, Ms Gardiner told us that when she started working at Ashley Youth Detention Centre in 2018, there was a change manager at the Centre whose work made a positive impact on the culture of the Centre.<sup>319</sup> She said that after this position was defunded, '[w]ithout someone driving the cultural change and relationship building from a leadership perspective, this cultural change was not maintained'.<sup>320</sup>

We recommend that the Department immediately appoints a culture change manager at Ashley Youth Detention Centre and that this position be maintained beyond the closure of the Centre for as long as monitoring indicates there is a need for this position.

## Recommendation 12.7

The Tasmanian Government should:

- a. develop measures to monitor and evaluate progress towards cultural change in youth detention and include these in the Outcomes Framework under the Youth Justice Blueprint and associated action plans
- b. include monitoring and evaluation of progress towards cultural change in youth detention in the Youth Justice Reform Governance Framework
- c. urgently begin data collection and monitoring of progress towards cultural change
- d. ensure there is an ongoing governance structure to oversee and monitor the functioning of the youth justice system, including the performance and culture of youth detention, beyond the implementation of the youth justice reforms

- e. fund the Department for Education, Children and Young People to immediately appoint a culture change manager at Ashley Youth Detention Centre reporting to the Centre Manager and whose role is to work with and support the Centre Manager to
  - i. drive cultural change in youth detention
  - ii. create a child safe organisation
  - iii. establish a positive, collaborative and supportive working environment
- f. maintain the culture change manager position or function beyond the closure of Ashley Youth Detention Centre for as long as monitoring indicates there is a need for it.

## 4.6 Empowerment and participation of children and young people in detention

As noted, a child safe culture is one in which children and young people are empowered to express their views about matters that affect them and where those views are taken seriously. In this section, we discuss children and young people’s participation in systemic processes or decision making in youth detention. Children’s participation in individual decision-making processes in youth detention (such as case planning, case management and exit planning) is addressed in Section 6.4.

### 4.6.1 Principles for children’s participation

Principle Two of the *National Principles for Child Safe Organisations* requires organisations to ensure ‘[c]hildren and young people are informed about their rights, participate in decisions affecting them and are taken seriously’.<sup>321</sup> As noted earlier, the Child and Youth Safe Organisations Act includes an identical principle as a Child and Youth Safe Standard.<sup>322</sup>

The Victorian Commission for Children and Young People has noted that to comply with the equivalent Victorian standard an organisation must ensure: children and young people are informed about their rights; support from peers and friendships is recognised and encouraged; and organisations have strategies in place to develop a culture that facilitates participation and responds to the input and contributions of children and young people.<sup>323</sup>

As noted earlier, we commissioned research into children and young people’s perceptions of safety in government funded organisations in Tasmania.<sup>324</sup> This research—the *Take Notice, Believe Us and Act!* report—highlighted the importance of children and young people’s empowerment and participation in institutions. It found that:

To feel confident, children and young people need to be respected, to be affirmed and to be equipped to identify and seek help when they are at risk of harm. This requires them to be informed and educated. It requires organisations to promote cultures that value children and young people and empower them as individuals and as a group.<sup>325</sup>

The report also found that ‘to feel safe and to have confidence in adults and organisations children and young people need to feel involved’:

Groups of young people can also play a role in identifying the concerns of their peers and providing feedback on an organisation’s approach to preventing and responding to abuse. Fundamental to individual and ‘collective’ engagement is for something to change. For ‘participation’ to be ‘protective’, children and young people must see how their views have been valued, acted on and how adults and organisations have built their appreciation of their needs and embedded them in their child safe strategies.<sup>326</sup>

Experts who gave evidence to our Commission of Inquiry also commented on the importance of children’s participation in organisations. Professor Palmer stated that children should be explicitly involved in the design of child safety measures and have the same status, in terms of rights and obligations, as adults, particularly the right to be believed.<sup>327</sup>

As we discuss elsewhere in our report, in 2021, the Victorian Commission for Children and Young People released *Empowerment and Participation – A Guide for Organisations Working with Children and Young People*.<sup>328</sup> According to this guide, the four key elements of participation for children and young people in organisations are:

- space—children and young people feel safe when they are in an environment where it is safe to speak up<sup>329</sup>
- voice—children and young people are not always used to being asked about their experience or about what they want, so organisations need to support them to feel comfortable speaking up and provide opportunities to do so<sup>330</sup>
- audience—adults and young people are effectively collaborating when adults in an organisation take young people’s views seriously and allow them to inform the way the organisation works<sup>331</sup>
- influence—for participation to be meaningful, participants should know the intention is to make changes that keep children and young people safe in the organisation.<sup>332</sup>

The New South Wales Office of the Advocate for Children and Young People published *A Guide to Establishing a Children and Young People’s Advisory Group* in 2021.<sup>333</sup> This guide identifies several principles for children’s participation, including:



- Membership of any advisory group should reflect children and young people’s diversity.
- Organisations should develop the capacity of children and young people to participate.
- Children and young people’s participation must be voluntary and informed.
- Participation should bring children and young people no harm—for example, children and young people who become distressed during meetings may need psychological support.
- Organisations should anticipate ethical issues that might arise from children’s participation, including keeping any information shared by children and young people confidential.<sup>334</sup>

We also note *Youth Matter: A Practical Guide to Increase Youth Engagement and Participation in Tasmania*, published by the former Department of Communities in 2019.<sup>335</sup>

#### 4.6.2 Participation at Ashley Youth Detention Centre

We identified that Ashley Youth Detention Centre has a procedure about a Resident Advisory Group (‘Resident Advisory Group Procedure’).<sup>336</sup> This procedure explains that the Resident Advisory Group is a forum:

... designed to give young people detained at [Ashley Youth Detention Centre] a say about the things that affect them. This includes listening to their views on the physical amenity of the site, detention processes, standard of care, treatment and program options and how safe they feel.<sup>337</sup>

The purposes of this group include ‘[c]reating safety by ensuring young people’s voices are heard’, ‘[s]upporting quality improvement processes’, ‘[p]roviding input into policy and procedure development’ and ‘[i]nformation sharing around on-site developments’.<sup>338</sup>

The Resident Advisory Group Procedure states that the group meets every six weeks and is attended by the Centre Manager and two staff from the Department’s Quality Improvement and Workforce Development unit (this unit no longer exists).<sup>339</sup> All children and young people are eligible to attend unless a risk assessment undertaken by the Operations Manager indicates otherwise.<sup>340</sup> Participation is voluntary.<sup>341</sup> A Resident Advisory Group meeting may comprise several small group sessions or, in some cases, a session with an individual child or young person.<sup>342</sup>

The Resident Advisory Group Procedure contains detailed rules for convening and conducting meetings, ensuring safety for children and young people and staff, and reporting and responding to issues that emerge in meetings.<sup>343</sup>

In particular:

- If a child or young person discloses abuse or neglect, the procedure directs staff to notify Child Safety Services.<sup>344</sup>
- If a child or young person makes a complaint during a meeting, the Centre Manager must instigate ‘the complaints process’ (this is discussed in Section 10.2).<sup>345</sup>
- The Centre Manager must prepare a response to all issues raised and provide this to the Department within five working days of the next Resident Advisory Group meeting.<sup>346</sup>

The Australian Childhood Foundation’s *Through the Fence* report recommended strengthening the role of the Resident Advisory Group ‘to ensure that young people have a voice in the [therapeutic practice] model development and within [Ashley Youth Detention Centre] generally’.<sup>347</sup> We did not receive any specific evidence about the operation of the Resident Advisory Group, or children and young people’s experiences with this group.

The Draft Youth Justice Blueprint states that the youth justice system should:

... actively engage with, and seek the views of children, young people and their communities and provide ongoing opportunities for children and young people with lived experience to be heard.<sup>348</sup>

However, it does not specify how this will be achieved for children and young people in detention. None of the Government’s reform documents refer to the Resident Advisory Group or any other participation or consultation mechanism for children and young people in detention.

### **4.6.3 Strengthening children’s participation in the detention system**

It is critical to develop a culture that empowers children and young people in detention and enables them to safely share their views on a range of issues, including policies, procedures, programs, services, system reforms and what makes them feel safe or unsafe. Such a culture should aim to build children and young people’s awareness, skills and knowledge to support their participation.

Given the previous lack of children’s participation at Ashley Youth Detention Centre, we consider that the Department for Education, Children and Young People should develop an empowerment and participation strategy for children and young people in detention, in consultation with the new Commission for Children and Young People (recommended in Chapter 18 at Recommendation 18.6 and discussed in Section 11.3). In our view, the guides to children’s empowerment and participation recently developed in Victoria and New South Wales provide appropriate tools to inform this strategy.

The Resident Advisory Group appears to be a positive way to seek feedback from children and young people in youth detention. However, there are several factors that limit its effectiveness as an ongoing consultation forum for children and young people to express their views. These include the vulnerability of children and young people in detention, the recent history of children and young people feeling unsafe or reluctant to raise concerns or express their views at Ashley Youth Detention Centre and the fact that children and young people may only be in detention for a relatively short period, leading to a lack of stability in the group's membership.

Accordingly, we recommend establishing a separate advisory group comprising children, young people and young adults up to the age of 25 years with previous experience of detention. While the terms of reference for this group should be set in consultation with young people, it should provide a forum for those with lived experience of youth detention to share their views on measures to empower children and young people in detention and create a child safe culture.

Membership of this advisory group should reflect the diversity of the detention population, and in particular should include Aboriginal people and people with disability. The advisory group should be convened by the Department for Education, Children and Young People and be attended by a senior representative of the Department. However, the group should be chaired by a person who is independent of the Department and has experience in working and consulting with vulnerable young people.

We also recommend a review of the Resident Advisory Group to ensure it conforms with best practice principles for children's participation and provides a safe forum for children and young people in detention to provide feedback and express their views.

## **Recommendation 12.8**

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

- a. the establishment of a permanent advisory group that
  - i. includes children, young people and young adults up to the age of 25 years with previous experience of youth detention in Tasmania, including Aboriginal people and people with disability
  - ii. has clear terms of reference developed in consultation with young people with experience of detention

- iii. enables its members to participate in a safe and meaningful way and express their views on measures to empower children and young people in detention (including the role and purpose of the Resident Advisory Group) and achieve cultural change in detention
  - iv. meets regularly and is chaired by a person independent of the Department and attended by a senior departmental leader
  - v. is adequately funded and resourced
- b. a review of the Ashley Youth Detention Centre Resident Advisory Group to ensure it conforms with best practice principles for children’s participation and provides a safe forum for children and young people in detention to express their views, including on measures to achieve cultural change in detention, without fear of reprisal
  - c. a consultation forum for children and young people in any youth detention facility that replaces Ashley Youth Detention Centre
  - d. mechanisms to ensure children and young people in detention are aware of their rights
  - e. regular monitoring and evaluation of the effectiveness of the empowerment and participation strategy.

## 4.7 Staffing

Another key component of cultural change in detention is ensuring youth workers are appropriately qualified, skilled, trained, supported and resourced to engage with and respond constructively to children and young people in detention, and their attitudes and personal attributes align with a therapeutic model of care for youth detention.

As discussed in Section 6, the best-performing youth detention facilities have highly skilled staff who actively engage with children and young people, model positive behaviour and can manage difficult behaviours through trauma-informed responses and de-escalation techniques. In these facilities, staff engagement with children and young people is key to supporting them to address their behaviours.

In Section 6.3.1, we describe models:

- in Spain, where the staff who have the day-to-day care of children and young people in secure facilities run by the Diagrama Foundation are known as ‘social educators’—these are specialists qualified to degree level who act as encouraging and supportive role models for children and young people, while setting ‘consistent, clear and fair boundaries to help young people understand the positive and negative consequences of their behaviour’<sup>349</sup>

- in Missouri and elsewhere in the United States, where staff who are responsible for the care and safety of children and young people in secure facilities are known as ‘youth specialists’—these staff undergo an intensive recruitment process to determine whether they are committed to helping children and young people succeed and have the necessary attributes for the role, and are also required to complete 236 hours of training in their first two years, including multiple sessions on youth development, family systems and group facilitation.<sup>350</sup>

In Section 6.3.4, we recommend that the Government ensures staff in youth detention facilities have the skills needed to undertake trauma-informed, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to the use of force or restrictive practices (Recommendation 12.18).

In the following discussion, we consider the qualifications and professional development necessary for youth workers in Tasmanian detention facilities to meet this standard. We also discuss staff shortages and recruitment.

#### **4.7.1 Staff qualifications and professional development**

##### **Youth workers’ qualifications and training**

Almost all the previous reviews into Ashley Youth Detention Centre summarised in Section 4.2.1 highlighted problems with youth worker capability, skills and training.

As noted in Section 4.2.2, we heard that most youth workers at Ashley Youth Detention Centre live in the local area. We also heard that many youth workers had minimal relevant qualifications (with a highest level of education of year 10 or year 12), had minimal previous relevant experience other than caring for their own children or being involved in a sporting club, and had found out about the youth worker position through word of mouth.<sup>351</sup>

According to Dr Guerzoni:

... historically the workforce at Ashley Youth Detention Centre have not been required to hold appropriate qualifications. Further, I understand that they have not been trained in working with juveniles and the facilitation of healthy relationships with children.<sup>352</sup>

In contrast, we also heard that some youth workers had relevant qualifications and experience when they started working at Ashley Youth Detention Centre. For example, Ms Spencer had a Certificate IV in Youth Justice and had worked at a youth detention centre in another state, while Ms Ray had youth worker qualifications from New Zealand and experience in working with children and young people.<sup>353</sup>

According to Recommendation 15.8 of the National Royal Commission:

State and territory governments should ensure that all staff in youth detention are provided with training and ongoing professional development in trauma-informed care to assist them to meet the needs of children in youth detention.<sup>354</sup>

Ms Ray told us that she was meant to have two weeks of training when she started at Ashley Youth Detention Centre (in 2002) but ‘only got four days because there was a riot. So, after day four I got put into a unit with 15 boys and three staff ... and 20 minutes later it all kicked off’.<sup>355</sup>

The *Ashley Youth Detention Centre Learning and Development Framework* (‘Learning and Development Framework’), introduced in 2020, refers to a ‘Beginning Practice program’ for new staff, to be completed over six weeks, which includes:

1. Online introduction units, to be completed prior to first day of onsite training
2. Class based training sessions covering each competency unit
3. Class based and onsite introduction to the varying roles throughout the centre
4. Eight days of onsite ‘buddy shifts’ across all shift types working alongside mentors and opinion leaders who have been specifically selected for their practice abilities and leaderships skills (specific training provided to mentors)
5. Buddy shifts with Ashley Team Support to gain exposure to varying roles within the centre
6. Individual supervision sessions
7. Teamwork activities
8. Group supervision.<sup>356</sup>

The Learning and Development Framework also specifies several mandatory training requirements for Ashley Youth Detention Centre staff. These include units called ‘Child and Adolescent Development’, ‘Respond Safely to Critical Situations’ and ‘Engagement, De-escalation and Restraint’.<sup>357</sup>

While we agree with the importance of training and professional development for youth workers, we are also conscious of the fact that many previous reviews have made recommendations for staff training and yet problems have continued to exist. We note, in particular, the Ombudsman’s observations in 2019 that the various reports on Ashley Youth Detention Centre ‘appear to be demonstrating that there has been training provided but that there is an underlying cultural issue affecting its adoption’.<sup>358</sup>

## Qualifications and induction programs in other jurisdictions

In his evidence, Mr Simcock stated that the Department was seeing if it could ‘replicate’ some of the qualifications of the youth justice workforce in the Northern Territory, where he was previously employed.<sup>359</sup> In the Northern Territory, youth justice officers do not need to have a qualification before applying for the position, but all officers are employed first through a 12-month contract, during which time they must complete a Certificate IV in Youth Justice, which is funded by the department.<sup>360</sup> This was a recommendation of the 2017 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory (‘Northern Territory Royal Commission’).<sup>361</sup>

In May 2022, the Northern Territory Government published its *Northern Territory Youth Detention Centres Model of Care*.<sup>362</sup> This document identifies several personal attributes as essential to enable youth justice centre staff to implement a therapeutic model of care.<sup>363</sup> These include:

- genuine care and compassion for young people in detention
- the belief that young people are in detention to be rehabilitated, not punished
- the capacity to build and maintain positive relationships with young people while maintaining professional boundaries
- the ability to model and uphold prosocial behaviour
- willingness to take a strengths-based approach and actively engage with and take part in all aspects of a young person’s rehabilitation.<sup>364</sup>

Other jurisdictions adopt a variety of approaches to qualifications and induction programs for youth detention centre staff. For example:

- in New South Wales, no substantive qualifications are required to become a youth officer, and new recruits undergo three weeks of full-time training to prepare them for entry-level duties<sup>365</sup>
- in Queensland, no substantive qualifications are required to become a detention youth worker, but ‘a Certificate IV in Youth Justice or a Diploma of Youth Justice are highly desirable’ and new recruits ‘must meet all competencies and standards’ specified in five weeks of induction training before being confirmed in the role<sup>366</sup>
- in Victoria, the Department of Justice and Community Safety provides youth justice worker recruits with ‘eight weeks of fully paid foundational training including a Certificate IV in Youth Justice’ to prepare them for their first day—once they begin service, youth justice workers ‘continue to earn [their] Certificate IV qualifications’<sup>367</sup>
- in South Australia, ‘[i]t is not essential to already have a Certificate IV in Youth Justice’ and the Department of Human Services ‘may be able to support eligible candidates to complete the required training’<sup>368</sup>



- in Western Australia, no substantive qualifications are required to become a youth justice officer, but new recruits must undertake a nine-month full-time training program that includes ‘on-the-job’ and ‘off-the-job’ training, and written and practical assessments.<sup>369</sup>

Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre in the Australian Capital Territory, told us that ‘[i]ndividuals applying for employment do not require any previous training or experience, other than a willingness to work with young people and make a difference’.<sup>370</sup> She said that operational staff must complete a seven-week induction program to be eligible for permanent appointment.<sup>371</sup> This induction is followed by two weeks of ‘buddy shifts’ before staff start in their role.<sup>372</sup>

Ms Grace said that a dedicated Training Officer was appointed at Bimberi Youth Justice Centre in March 2020.<sup>373</sup> In addition, the ‘Principal Practitioner’ provides training to staff to ensure services are trauma-informed and therapeutic, including mandatory training for all new operational staff on ‘professional boundaries and self-disclosure, self-care and resilience and working with [Child and Youth Protection Services]’.<sup>374</sup>

### **Efforts to strengthen youth worker qualifications and skills in Tasmania**

The Draft Youth Justice Blueprint and Draft First Action Plan acknowledge that an effective youth justice system requires a ‘highly qualified and trained workforce’, although the Draft Youth Justice Blueprint also notes that Tasmania’s population size creates a challenge to ensuring suitably qualified staff.<sup>375</sup>

The Draft Youth Justice Blueprint also refers to the goals of ‘[b]uilding capacity within the workforce so that all staff have the required skills and capabilities for their role’ and ‘[s]trengthening professional learning opportunities in trauma-informed and therapeutic approaches to practice’.<sup>376</sup> The Draft First Action Plan refers to the ‘[i]ncreased professionalism of [the] workforce’, ‘[i]ncreased staff training and skill development’ and ‘[i]ncreased safety for staff, children and young people’ as expected outcomes of key actions under the plan.<sup>377</sup>

According to the Keeping Kids Safe Plan, ‘[t]he intent is that all youth workers have appropriate qualifications for the roles they are undertaking, underpinned by a trauma informed therapeutic approach’.<sup>378</sup> The plan commits to providing the Certificate IV in Youth Justice, delivered by the Australian Childhood Foundation, to existing staff and ‘any new staff who require the qualification’.<sup>379</sup>

During the hearings, Professor White observed that:

... usually a Certificate IV is a basic qualification, and often, but not always, it’s a tick and flick exercise ... So it’s substantively not particularly onerous and doesn’t really do much more than provide minimal training, but it’s not training as a youth worker, it’s training as a custodial [worker], and there’s a big difference.<sup>380</sup>

The 2016 Noetic Solutions options paper similarly indicated that stakeholders ‘overwhelmingly suggested’ that the Certificate IV qualification was not sufficient to support young people with complex needs in a custodial setting.<sup>381</sup> Professor White emphasised the need for both ‘in-service and pre-service’ education and training for youth workers.<sup>382</sup>

According to the Keeping Kids Safe Plan, the Department contracted the Australian Childhood Foundation in September 2022 to review the Learning and Development Framework and undertake a workforce analysis, which included examining ‘[m]inimum qualifications of all roles’ and ‘[p]osition descriptions and core capabilities’.<sup>383</sup> We have not been provided with the results of this review or analysis.

Before turning to our recommendations on staff qualifications, we discuss staff shortages and recruitment.

## 4.7.2 Staff shortages and recruitment

### Understaffing and resourcing challenges in detention

As noted in Section 4.2.2, we heard extensive evidence about understaffing and resource challenges at Ashley Youth Detention Centre.

Fiona Atkins, who started working at the Centre in 2000, recalled in her evidence that staffing pressures emerged in the early 2000s as a result of reduced funding.<sup>384</sup> She explained that, around this time, Ashley Youth Detention Centre began relying more heavily on private security personnel to cover shifts in response to staffing shortages.<sup>385</sup>

The 2007 report of the Legislative Council Select Committee (referred to in Section 4.2.1) observed that mandated staffing levels at Ashley Youth Detention Centre were not being maintained or were inadequate to ensure the safety and security of young people and existing staff.<sup>386</sup>

We heard that staff shortages at Ashley Youth Detention Centre have only worsened since then and that understaffing has created unsafe conditions for staff and for children and young people in detention.<sup>387</sup>

Mr Morrissey told us that, during his time as Commissioner for Children and Young People (2014 to 2017), there were instances where he made unannounced visits to Ashley Youth Detention Centre to check on the children and young people detained there.<sup>388</sup> Mr Morrissey recalled there were occasions when he had difficulty accessing the Centre, and left without having spoken to any young people—a situation he assumed to be related, in part, to reduced staffing levels.<sup>389</sup> He also told us he was aware of children and young people being locked in their rooms alone for periods of up to two weeks or more due to staffing shortages, which he characterised as a ‘form of torture’.<sup>390</sup>

Understaffing also inevitably leads to reduced supervision of children and young people by a smaller pool of staff. This increases the vulnerability of children and young people in detention to physical or sexual abuse by staff or other detainees—a fact acknowledged by Lucas Digney, Assistant State Secretary, Health and Community Services Union (Tasmania Branch), during our hearings.<sup>391</sup>

Victim-survivor Max told us about an incident where he alleged that he was physically abused by another young person while there was only one staff member available to supervise.<sup>392</sup> He told us that ‘[h]aving only one worker means that if there is an incident, they can’t do anything other than call a code black and wait for other youth workers to arrive’.<sup>393</sup>

As noted in Section 4.2.2, Ms Ray referred to ongoing staff shortages over a period of several years before 2022:

... you want the best out of a young person you need to nearly have one-on-one staff ratio to residents ... there was always constraints over budget, over staffing, they never did enough recruitment, we couldn’t keep enough people, so for a whole period of four years there was quite a cohort of staff who were working three and four 12-hour shifts a week. Now, under those circumstances, in a 24/7 alert level situation, that’s a lot for the human brain to take on for a long period of time.<sup>394</sup>

Ms Spencer told us that, at the time of our hearings in August 2022, children and young people were on ‘rolling lockdowns’ due to staff shortages—this meant confining children and young people to their rooms or units for longer than usual and releasing them at staggered times rather than all together.<sup>395</sup> We discuss lockdowns in detail in Section 9.2.

Ms Atkins attributed recent staff shortages to several factors: the standing down or suspension of staff in response to allegations made against them; the forthcoming closure of Ashley Youth Detention Centre; COVID-19 restrictions; the perception among some staff that young people at the Centre may make false allegations against them; an increase in workers compensation claims; and negative depictions of Ashley Youth Detention Centre in media reporting.<sup>396</sup>

Mr Digney identified staff shortages as a management issue caused by under-resourcing, poor working conditions, employment-related injuries and a lack of staff retention.<sup>397</sup> He stated:

Staff shortages damage employee morale and heighten workloads. It creates a significant safety risk. This consequentially harms the standard of service which employees can provide to detainees. Further, detainees see it as isolation, which, in the view of [the Health and Community Services Union], it is. This can often make them agitated and more difficult to engage with. It leads to frustration and confrontation between staff and detainees.<sup>398</sup>

At our hearings, Mr Digney said that, while there had been some recent improvement in the staffing situation at the Centre, the shortages continued, with the Centre relying on staff working overtime to cover the minimum shifts required.<sup>399</sup> This continued to place the safety of children at risk.

Secretary Pervan acknowledged that staff shortages had been a longstanding problem at Ashley Youth Detention Centre and referred to several barriers to recruitment:

I do not recall a time when the levels of staff with the necessary skills [were in place] to support the transformation of the [Ashley Youth Detention Centre] service. This is a function of both available funding and our ability to recruit and retain staff with the necessary skills. Since I became Acting Secretary, we have similarly not had staffing numbers to support [Ashley Youth Detention Centre] staff to undertake substantial periods of training away from the workplace without leaving the Centre chronically understaffed. This is the practical reality within which we operate given our budget, the location of the facility, staff turnover levels, the difficulty of these jobs and the high levels of sick leave. It also reflects the financial reality of our State with Government having to determine funding from fixed revenues across intensely competing demands in health, education, justice and so on.<sup>400</sup>

Secretary Pervan expanded on his comments at the hearings:

In an ideal world you would have sufficient staffing so that you could maintain full safe staffing while you had other staff away from the service undertaking training and development and bringing them up to speed with an emerging area which is therapeutic care. The dynamic at Ashley is that, because of staff turnover, we've never actually ever been able to get a full permanent workforce up there so that there has been times, as we all know, when we've been unable to maintain full safe staffing without using overtime and double shifts and things like that.<sup>401</sup>

We understand that, as recently as July 2023, lockdowns related to staff shortages continued at the Centre, with children and young people locked in their rooms or units for up to 23 hours each day.<sup>402</sup>

### **Efforts to address staff shortages in detention**

In June 2022, a health and safety representative at Ashley Youth Detention Centre issued a Provisional Improvement Notice to the Centre on the basis that the Department was not taking enough action on staff shortages and there was an 'imminent risk to [union] members' health and safety'.<sup>403</sup> In August 2022, Mr Digney stated that there had been no support from the safety regulator WorkSafe Tasmania on this issue, nor had the Department provided immediate contingency staff.<sup>404</sup>

Correspondence from Mr Digney in June 2022 to Jacqueline Allen, former Acting Executive Director, People and Culture in the Department of Communities, stated that staffing at Ashley Youth Detention Centre was at a point where it was 'dangerous for workers and young people alike'.<sup>405</sup> In her response to this email, Ms Allen indicated that

a number of measures were being implemented, including recruiting new youth workers, support from other service areas, health and wellbeing support and ‘appropriate restrictions on movement of young people’ in recognition of the current staffing levels.<sup>406</sup> The reference to ‘restrictions on movement of young people’ appears to be a reference to lockdowns.

The Draft Youth Justice Blueprint refers to the aim of ‘maintaining staffing levels with experienced and competent staff’.<sup>407</sup> Similarly, the Draft First Action Plan states that it aims to maintain an ‘adequate staffing complement’ and identifies ‘[i]ncreased staffing’ as one of its intended outcomes.<sup>408</sup>

Objective 2 of the Keeping Kids Safe Plan is to maintain ‘an appropriate level of staff with the right experience and competencies’ at Ashley Youth Detention Centre.<sup>409</sup> This includes the following action items:

- developing and implementing a ‘Youth Justice Services Workforce Strategy’, to be implemented by January 2023<sup>410</sup>
- appointing a Director, Custodial Operations for 12 months from September 2022 (referred to in Section 4.4.1)<sup>411</sup>
- seconding five youth workers from the Northern Territory for 12 months from October 2022 to supplement staffing at the Centre<sup>412</sup>
- employing retired police officers from September 2022 to assist youth workers in a ‘support and mentor capacity’<sup>413</sup>
- making a concentrated effort to recruit more youth workers<sup>414</sup>
- restructuring the workforce at the Centre from the end of 2022 to ‘ensure all relevant roles are geared to a strong trauma informed and therapeutic service delivery approach’<sup>415</sup>
- appointing more leadership positions at the Centre from the end of 2022.<sup>416</sup>

In February 2023, Timothy Bullard, Secretary, Department for Education, Children and Young People, advised us that:

- two Assistant Managers, one Operations Manager and 13 youth workers had been appointed for 12 months ‘to provide an immediate boost’ to the workforce<sup>417</sup>
- in terms of ongoing recruitment, 10 youth workers had been appointed in October 2022 and had completed a five-week induction course in January 2023, with another 25 applicants to be interviewed ‘shortly’<sup>418</sup>
- since 13 December 2022, Ashley Youth Detention Centre had been ‘sufficiently staffed to cease restrictive practices, enabling school attendance and full daily programs for young people’.<sup>419</sup>

We have not been advised whether other pending action items under Objective 2 of the Keeping Kids Safe Plan have been completed.

On 12 July 2023, the Commissioner for Children and Young People, Leanne McLean, informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, with ‘isolation practices and unit-specific lockdowns, operating outside an accepted policy framework, and restrictive practices for operational reasons’ continuing to be used at Ashley Youth Detention Centre.<sup>420</sup> She advised that, over the previous six months, her office had observed (among other practices):

- An increase in incidents involving extensive damage to property (e.g., flooding cells, lighting fires, activating fire sprinklers) and/or self-harm (e.g., swallowing batteries, cutting) during extended periods of lockdown; and
- Young people’s access to the school, programs, fresh air, exercise, medical treatment, contact with their legal representatives and visits being restricted due to lockdowns.<sup>421</sup>

Commissioner McLean also said that ‘[t]he promotion of children’s human rights is trumped time and time again by staff shortages or workplace health and safety considerations, euphemistically referred to as “operational reasons”’.<sup>422</sup> This information is extremely concerning.

We note that Commissioner McLean has previously called on the Government to ‘urgently establish a rapid response crisis team on the ground at Ashley Youth Detention Centre, inclusive of specialist leadership skills and child safe practitioner expertise’, which should focus on ‘the wellbeing of detainees and the wellbeing of the staff who remain at the centre’.<sup>423</sup>

In response to Commissioner McLean’s July 2023 comments, the Government acknowledged that, despite the employment of additional staff at Ashley Youth Detention Centre, the Centre ‘continue[d] to experience critically low staff numbers turning up to work on some days’.<sup>424</sup> Secretary Bullard stated that restrictive practices:

are implemented only when absolutely necessary and are structured to ensure young people at [Ashley Youth Detention Centre] have continued access to education, phone calls and health appointments.<sup>425</sup>

Secretary Bullard also said that the Government was continuing to work on measures to address staff shortages at the Centre, including commencing another recruitment round for youth workers, exploring the reasons for high rates of absenteeism and recruiting additional leadership roles into the Youth Justice portfolio.<sup>426</sup>

## Support for staff

Institutional child sexual abuse has profound effects on the staff of an institution, who have been colleagues with those who have offended or against whom allegations have been made, and who have worked within the culture of the institution that enabled the abuse. The impact on staff is particularly acute in the context of Ashley Youth Detention Centre, where there are numerous staff who are the subject of allegations (refer to Chapter 11, Case studies 1 and 7).

Counsel Assisting our Inquiry asked Ms Honan what supports had been put in place for staff at Ashley Youth Detention Centre in response to the serious allegations against their colleagues.<sup>427</sup> Ms Honan said there was a health and wellbeing officer on site, staff had been accessing counselling and support services, and Ms Honan had also increased her presence on site to be available to speak to staff.<sup>428</sup>

As discussed in Chapter 15, the sexual abuse of a child in an institution, particularly by a staff member who has worked in that institution for an extended period, can be understood as a critical incident. In that chapter, we recommend that the Department of Health develops and implements a critical incident response plan for human-caused traumatic events, including incidents relating to child safety such as child sexual abuse (Recommendation 15.19). Among other matters, this plan should:

- identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements
- provide for early communication of information about the incident
- provide psychological first aid to affected people and extra support from skilled psychologists on an 'as needs' basis
- facilitate communication and support among affected people as a means of social support
- provide for critical incident debriefing facilitated by a neutral and trained expert where appropriate
- provide for a review of the Department of Health's response to the critical incident
- provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident.

We note that the Department already has procedures for responding to incidents in detention, which we discuss in Sections 9.3 and 10.2. However, we consider that aspects of Recommendation 15.19 should be adapted to ensure staff at Ashley Youth Detention Centre dealing with the ramifications of extensive allegations of abuse against colleagues and their subsequent suspensions (and actual or potential terminations) receive the necessary support.



### 4.7.3 Our recommendations

As noted throughout this chapter, most children and young people in detention have highly complex needs and challenging behaviours. The practice of employing youth workers at Ashley Youth Detention Centre with limited qualifications or experience in working with vulnerable children and young people has, without doubt, contributed to many of its cultural problems. Failing to equip unqualified staff with the skills needed to provide appropriate care and support for children and young people in detention has clearly exacerbated these problems.

Staffing is a critical component in implementing meaningful cultural change in youth detention—change cannot occur if youth workers resist it. As we have seen time and again, reviews and recommendations have failed to result in effective change to the culture at Ashley Youth Detention Centre. As Dr Cromptvoets observed:

Sometimes an organisation needs a complete reset, and there are definitely examples across the world where an organisation or a part of an organisation are actually completely shut down and rebuilt from the ground up to be fit for purpose ...<sup>429</sup>

Staff who work with children and young people in detention must be appropriately qualified and trained, and have the necessary attributes, attitudes and skills to build positive relationships with children and young people and create a child safe culture. In our view, this cannot be achieved in Tasmania without a thorough review of current staffing qualifications, personal aptitudes, capabilities and training.

To this end, we recommend that the Department initiates a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers, and requires all current staff to reapply for their positions. We consider that such a process is essential to change the culture in youth detention. It will also enable staff who are reappointed to clearly identify themselves as being a part of Tasmania's future youth detention system, rather than its past. The Government should consider whether the change management process should also apply to other staff at Ashley Youth Detention Centre.

As noted, the Australian Childhood Foundation is undertaking a workforce analysis in respect of Ashley Youth Detention Centre, which includes examining the minimum qualifications of all roles, position descriptions and core capabilities.<sup>430</sup> We welcome the Department's initiative to provide a Certificate IV qualification for youth workers. However, we are concerned that this qualification does not provide the right degree of skill to provide a therapeutic response to children with complex needs. Nevertheless, we accept that it may not be feasible at present to require all youth workers to hold a higher qualification.

In our view, youth workers should hold or be supported to obtain a relevant Certificate IV as a minimum qualification. The Department should also support youth workers to

undertake further education such as a diploma or bachelor-level qualification, graduate certificate or micro-credentials. Youth workers who complete higher qualifications should be eligible for promotion to a new role of senior youth worker, with a higher level of remuneration. Senior youth workers must also have consistently demonstrated the attributes, attitudes and skills to build positive relationships and a commitment to rehabilitation and working therapeutically with children and young people in detention. Existing staff reapplying for a youth worker position through the recommended change management process should not be required to hold a Certificate IV, but the Department should support reappointed youth workers to obtain such a qualification within 12 months of reappointment as a condition of continuing employment.

We also recommend adopting a more rigorous method of recruitment for youth workers that considers a person's attributes (such as empathy, care, compassion and listening skills), attitudes to children and young people in detention, and relationship-building skills.<sup>431</sup> As Adjunct Associate Professor Mitchell advised, relationship building is a critical skill for a youth worker:

... a relationship-based approach would be part of a practice framework. It says to the youth workers or the custodial staff: Your job is not to stand back and watch; your job is to be engaged with and use your relationship as a vehicle for change; your job is not to stand back and do nothing until you have to intervene to de-escalate something. So it sets the tone and the orientation for how change happens, for how learning happens and how we set goals and measure success.<sup>432</sup>

We also welcome the Department's review of the Learning and Development Framework. Induction programs and ongoing training and professional development for youth workers should reflect best practice in youth detention. They should focus on children and young people's human rights, particularly in relation to the use of isolation, force and personal searches, with training in all custodial policies and procedures. However, they should also include approaches to setting fair, clear and firm boundaries for children and young people's behaviour. Youth workers should also benefit from supervision from qualified professionals and opportunities for reflective practice.

Newly recruited youth workers should not be eligible to start work until they have satisfactorily completed the induction program. This should be followed by two weeks of 'buddy shifts' before starting in their role.

Also, to support ongoing cultural change in youth detention, the Department should develop a clear policy on the appropriateness of providing training, counselling or direction to detention centre staff members who have repeatedly demonstrated resistance to change.

We recommend that the Department maintains a sufficient level of youth workers to implement the therapeutic model of care in youth detention discussed in Section 6.3 (Recommendation 12.18) and to support a child safe culture in detention. In particular, this level of staffing should be high enough to:

- ensure children and young people’s human rights are respected (including their right not to be subjected to unlawful isolation or unnecessary lockdowns) and their health, cultural and educational needs are met
- support the safety and wellbeing of youth workers, including allowing time for rest breaks, reporting, debriefs on critical incidents and handovers
- enable youth workers to undertake ongoing professional development.

We also recommend that the Department undertakes an ongoing biannual recruitment process to maintain adequate staffing levels.<sup>433</sup>

We acknowledge that these recommendations, which are aimed at long-term reform, may not meet the urgent need to address immediate and ongoing staff shortages. We also acknowledge that our recommendation for a change management process may add to pressure on staffing levels in the short term. The Government must urgently develop a staffing contingency plan for youth detention to ensure children and young people in detention are not subjected to unnecessary lockdowns and that their rights are not trumped by ‘operational’ considerations.

The Government should also consider other ways to attract youth workers, such as a salary allowance or loading that reflects the regional location of Ashley Youth Detention Centre and the current high-risk environment of youth detention.

We also recommend strengthening the Department’s support for staff at Ashley Youth Detention Centre in dealing with the fallout of the allegations of abuse against their colleagues and the intense scrutiny of the Centre arising from our Commission of Inquiry. More broadly, we recommend extra support for youth workers and other staff at detention facilities following critical incidents in detention, including riots, assaults, attempted suicide and self-harm. This should include providing psychological first aid, additional support from skilled psychologists on an ‘as needs’ basis and, where appropriate, critical incident debriefing facilitated by a neutral and trained expert.

## **Recommendation 12.9**

The Department for Education, Children and Young People should:

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

- b. ensure individuals recruited to the youth worker role hold a relevant Certificate IV qualification before starting or complete such a qualification within a year of starting, and have appropriate attributes, attitudes and skills to build positive relationships and work therapeutically with children and young people in youth detention
- c. create incentives for ongoing professional development by supporting youth workers to complete higher qualifications and providing for operational career progression to a senior youth worker role
- d. maintain a sufficient level of youth workers to implement a therapeutic model of care in youth detention and to ensure the safety and wellbeing of children, young people and staff
- e. establish an ongoing biannual recruitment process for youth workers
- f. ensure the induction program and continuing professional development for youth workers are based on best practice principles and include
  - i. expected standards of behaviour in interacting with children and young people
  - ii. a focus on children and young people's human rights, particularly in relation to isolation, force, restraints and personal searches
  - iii. approaches to setting fair, clear and firm boundaries for children and young people's behaviour within a therapeutic, trauma-informed framework
  - iv. training in all custodial policies and procedures
- g. ensure newly recruited youth workers are not eligible to start work until they have satisfactorily completed the induction program, followed by two weeks of 'buddy shifts'
- h. develop a clear policy on the appropriateness of providing training, counselling or direction to detention centre staff members who have repeatedly demonstrated resistance to change
- i. urgently develop a staffing contingency plan to ensure children and young people in detention are not subjected to lockdowns caused by staff shortages
- j. consider introducing mechanisms to attract more youth workers, such as an allowance or loading that reflects the regional location of Ashley Youth Detention Centre and the current high-risk environment of youth detention
- k. implement other supports for Ashley Youth Detention Centre staff in relation to allegations of child sexual abuse against their colleagues and strengthen support for youth workers and other detention centre staff following critical

incidents in detention, such as riots, assaults, attempted suicide and self-harm, by providing psychological first aid, additional support from skilled psychologists on an 'as needs' basis and, where appropriate, critical incident debriefing facilitated by a neutral and trained expert.

## 4.8 A professional conduct policy

The National Royal Commission identified an increased risk of institutional child sexual abuse when expectations of conduct between staff and children are not clear or consistently enforced.<sup>434</sup> This clarity and consistency can be achieved through a code of conduct for staff. As part of an institution's governance framework, a code of conduct can contribute to creating a child safe culture and facilitate child safe outcomes for the children in an institution.<sup>435</sup>

As discussed in Chapter 20, the State Service Code of Conduct, contained in section 9 of the *State Service Act 2000*, and the State Service Principles, found in section 7 of that Act, establish standards of behaviour and conduct that apply to all State Service employees. In her evidence, Ms Allen acknowledged that one of the limitations on the People and Culture team's ability to investigate complaints or take disciplinary action was the absence of provisions in the State Service Code of Conduct relating directly to child safety or child abuse.<sup>436</sup>

In Chapter 20, we recommend that each Head of Agency whose department provides services to children develops a professional conduct policy for the department's employees (Recommendation 20.2). This policy should:

- explain what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
- define and prohibit child sexual abuse, grooming and boundary violations
- acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about, and examples of how to manage conflicts of interest and professional boundaries in small communities
- provide guidance on identifying behaviours that indicate child sexual abuse, grooming and boundary violations relevant to the particular organisation
- outline behaviours that must be reported to authorities, including what behaviours should be reported to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator of the Reportable Conduct Scheme or other relevant agencies
- provide that not following reasonable directions is a breach of professional standards

- provide that a failure to report a breach or suspected breach of the policy may be taken to be breach of the policy
- outline the protections available to individuals who make complaints or reports in good faith
- provide and clearly outline response mechanisms for alleged breaches of the policy
- specify the penalties for a breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the Code has been breached, and may result in disciplinary action
- refer to any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaints handling or child protection policies, or other codes of conduct relevant to particular professions.

The professional conduct policy should also be:

- easily accessible to everyone in the agency and communicated by a range of mechanisms
- explained to, acknowledged and signed by all employees
- accompanied by a mandatory initial training session and regular refresher training
- communicated to children and young people and their families through a range of mechanisms, including on the agency's website.

There appears to be no professional conduct policy that applies to staff at Ashley Youth Detention Centre. There is also no mention of a code of conduct or professional conduct policy in the Draft Youth Justice Blueprint, Draft First Action Plan or Keeping Kids Safe Plan.

In implementing Recommendation 20.2, the Department should ensure it develops a separate professional conduct policy for staff who have contact with children and young people in youth detention and other residential youth justice facilities. This professional conduct policy may specify general standards of behaviour as well as those specific to particular roles such as youth workers, education staff or health staff working in youth detention or other youth justice facilities.

The professional conduct policy for youth detention should specify expectations outlined in other relevant custodial policies and procedures, including those regarding personal searches of children and young people in detention and the use force and isolation (discussed in Section 9).

## Recommendation 12.10

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

- a. there is a separate professional conduct policy for staff who have contact with children and young people in detention facilities and other residential youth justice facilities
- b. the professional conduct policy for detention facilities and other residential youth justice facilities, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant custodial policies and procedures, including those on the use of force, isolation and personal searches of children and young people in detention
- c. the professional conduct policy for youth detention and other residential youth justice facilities spells out expected standards of behaviour for volunteers, contractors and sub-contractors
- d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy.

## 5 Reducing the number of children in youth detention

Children and young people in youth detention facilities are at increased risk of child sexual abuse by adult abusers and children and young people engaging in harmful sexual behaviours.<sup>437</sup> An important mechanism to minimise this risk is to reduce the number of children and young people entering detention. This requires a range of strategies to prevent children and young people becoming involved with the youth justice system, divert those who come into contact with police away from formal criminal justice processes, and ensure children and young people who do face criminal proceedings are supported to address their offending behaviour in the community rather than in detention.

As noted in Section 2, the Draft Youth Justice Blueprint and Draft First Action Plan emphasise prevention, early intervention and diversion. The broad directions of the Government's youth justice reform agenda are positive, but many of the proposed reforms are yet to be developed in detail.

Accordingly, in this section, we recommend specific measures to reduce the number of children and young people entering detention by:

- raising the minimum age of criminal responsibility to 14 years and working towards raising the minimum age of detention to 16 years



- updating the principles of the Youth Justice Act
- increasing opportunities for pre-court diversion
- improving access to bail for children and young people and reducing the number of children and young people on remand
- ensuring detention is a sentence of last resort for children and young people.

While these measures would apply to all children and young people who come to the attention of the criminal justice system, our view is that the heightened risk of child sexual abuse in youth detention justifies us making recommendations to keep children and young people out of detention.

## 5.1 Age-appropriate responses to children and young people

### 5.1.1 Minimum age of criminal responsibility

The minimum age of criminal responsibility in Tasmania is 10 years.<sup>438</sup> This means children as young as 10 can be arrested, questioned, searched, detained by police, charged, subjected to forensic procedures, remanded in custody, convicted of an offence and sentenced to a range of dispositions, including detention. While the legal presumption of *doli incapax* (meaning ‘incapable of crime’) applies to children under the age of 14 years, as it does across Australia, the Victorian Commission for Children and Young People has observed that this is an ineffective safeguard for children aged 10 to 13 years against the harmful effects of criminal justice processes.<sup>439</sup>

According to data published by the Australian Institute of Health and Welfare in March 2023, there were five children aged 10 to 13 years in detention and seven children aged 10 to 13 years under community-based youth justice supervision in Tasmania during the 2021–22 year.<sup>440</sup> Ms Atkins told us that, in August 2022, at least one child as young as 11 was being held on remand.<sup>441</sup>

Research indicates that detaining children and young people is damaging, has a criminalising effect and does not reduce reoffending.<sup>442</sup> According to Vincenzo Caltabiano, former Director of Tasmania Legal Aid:

An incredibly high number of children who are detained at Ashley Youth Detention Centre find themselves back at Ashley Youth Detention Centre within a relatively short period of time. Over half of children aged 10–16 years return to supervised detention within 12 months of release. The general experience is that, if a child goes to Ashley Youth Detention Centre and spends any length of time there, their odds of staying in the system increase dramatically.<sup>443</sup>

There is a growing consensus among legal, human rights, medical and health organisations—in particular Aboriginal organisations—that such a low minimum age of criminal responsibility is harmful and unacceptable.<sup>444</sup> According to the Law Council of Australia:

The current low minimum age of criminal responsibility is out of step with international human rights standards and the most recent medical evidence on child cognitive development. It also ignores the large body of social research highlighting the harmful effects of early contact with the criminal justice system, including entrenchment and recidivism, and a correlation with being less likely to complete education or find employment. Further, it ignores the social determinants that lead to certain cohorts, such as First Nations children, children in out-of-home care, and children with significant health issues, being disproportionately represented in the criminal justice system.<sup>445</sup>

In its 2021 inquiry into the over-representation of Aboriginal children and young people in the Victorian youth justice system, the Victorian Commission for Children and Young People found that Victoria's low minimum age of criminal responsibility—also 10 years—disproportionately harms Aboriginal children.<sup>446</sup> It recommended that Victoria's minimum age of criminal responsibility be increased to 14 years, without exceptions.<sup>447</sup>

This followed other Australian children's commissioners, including Tasmania's Commissioner for Children and Young People, recommending, in 2019, an increase in the minimum age of criminal responsibility to at least 14 years.<sup>448</sup> Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service have also advocated implementing this change in Tasmania.<sup>449</sup>

Also in 2019, the United Nations Committee on the Rights of the Child recommended that the Australian Government raise the age of criminal responsibility to the 'internationally accepted level ... of 14 years'.<sup>450</sup> The former Council of Attorneys-General formed a working group to develop a nationally consistent approach to this issue and, in 2021, agreed to develop a proposal to raise the age of criminal responsibility from 10 to 12 years.<sup>451</sup> In December 2022, the Australian Government released a draft report prepared by the working group in 2020 for the Council of Attorneys-General that recommended the Commonwealth, state and territory governments raise the age of criminal responsibility to 14 years without exception, noting that jurisdictions did not reach consensus on this issue.<sup>452</sup>

Some jurisdictions have not waited for a national consensus to be reached. In November 2022, the Northern Territory Parliament passed legislation to increase the minimum age of criminal responsibility in the Northern Territory to 12 years.<sup>453</sup> In April 2023, the Victorian Government announced that Victoria would raise the minimum age of criminal responsibility to 12 years by late 2024, and to 14 years by 2027.<sup>454</sup> In May 2023, a Bill was introduced to the Australian Capital Territory Legislative Assembly, which was then referred to a committee inquiry, to raise the minimum age of criminal responsibility to 12 years upon commencement, and to 14 years by July 2025.<sup>455</sup>

The Tasmanian Government has committed to increasing the minimum age of detention to 14 years by the end of 2024 (discussed in Section 5.1.2), but has said that it will continue to consider the minimum age of criminal responsibility through the national Meeting of Attorneys-General, given the Tasmanian Government's preference for a nationally consistent position on this issue.<sup>456</sup>

In response to a request for advice from the Commissioner for Children and Young People, in April 2022, the Tasmania Law Reform Institute published a research paper examining the law reform considerations associated with raising the minimum age of criminal responsibility in Tasmania.<sup>457</sup> Among other questions, the Law Reform Institute considered what additional law reform would be required to ensure community safety and to promote the wellbeing of children under the minimum age of criminal responsibility who exhibit harmful behaviours.<sup>458</sup> The Law Reform Institute's recommendations included expanding the definition of when a child is 'at risk' under the Children, Young Persons and Their Families Act, so a child protection approach could be taken to children under the age of criminal responsibility who are engaging in 'serious or persistent "offence like" conduct' and/or whose behaviour 'generates a risk' to the child or other people.<sup>459</sup>

In our view, children under the age of 14 years who are engaging in harmful or antisocial behaviour should receive a child protection or a health system response rather than a criminal justice system response. Criminalising children in this age group increases the likelihood they will 'become entrenched in the youth justice system'.<sup>460</sup> It also increases the likelihood they will serve a custodial sentence in adult prison.<sup>461</sup> Increasing the age of criminal responsibility to 14 years would help protect younger children against these risks and the increased risk of sexual abuse as a result of that exposure to the youth justice system.

In relation to exceptions for children under the age of 14 years who engage in certain categories of harmful behaviour, we note that the United Nations Committee on the Rights of the Child has indicated it:

... is concerned about practices that permit the use of a lower minimum age of criminal responsibility in cases where, for example, the child is accused of committing a serious offence. Such practices are usually created to respond to public pressure and are not based on a rational understanding of children's development. The Committee strongly recommends that States parties abolish such approaches and set one standardized age below which children cannot be held responsible in criminal law, without exception.<sup>462</sup>

We agree with this approach.

## 5.1.2 Minimum age of detention

As noted in Section 5.1.1, the Tasmanian Government has committed to increasing the minimum age of detention to 14 years, with '[e]xceptions for serious crimes, and in the interest of community safety', to be identified during development.<sup>463</sup> As part of this commitment, the Government has indicated that it will develop new bail and sentencing options for children under 14 years, and that as 'new initiatives are developed and implemented, we will be able to remove detention as an option for this younger, more vulnerable cohort'.<sup>464</sup>

The United Nations Committee on the Rights of the Child recommends that:

... no child be deprived of liberty, unless there are genuine public safety or public health concerns, and encourages State parties to fix an age limit below which children may not legally be deprived of their liberty, such as 16 years of age.<sup>465</sup>

Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service both support an increase to the minimum age of detention to 16 years in Tasmania.<sup>466</sup> In 2021, the Victorian Commission for Children and Young People also recommended that the minimum age of detention in Victoria be increased to 16 years.<sup>467</sup>

We agree with this approach, but note the need for alternatives to detention—for example, inpatient mental health or drug and alcohol treatment (discussed in Section 6.5.2)—to be developed for children aged 14 and 15 years who commit serious offences against the person before such a change can be implemented.

### Recommendation 12.11

The Tasmanian Government should:

- a. introduce legislation to increase the minimum age of criminal responsibility to 14 years, without exception
- b. develop and provide a range of community-based health, welfare and disability programs and services that are tailored to meet the needs of children and young people under the age of 14 years who are engaging in antisocial behaviour, and to address the factors contributing to that behaviour
- c. work towards increasing the minimum age of detention (including remand) to 16 years by developing alternatives to detention for children aged 14 and 15 years who are found guilty of serious violent offences and who may be a danger to themselves or the community.

## 5.2 Updating the principles of the Youth Justice Act

The Government has committed to reviewing the Youth Justice Act as a priority under its Draft Youth Justice Blueprint, with a Bill to be delivered by 2025.<sup>468</sup> The purpose of the review is to ‘realign the legislation to a public health approach to youth justice and to be reflective of contemporary youth justice practice’.<sup>469</sup> The review will consider the following issues (among others):

- aligning the legislation with key human rights and youth justice principles
- adopting a trauma-informed, child-focused approach
- reflecting the importance of restorative justice and rehabilitation
- increasing the focus on early intervention and diversion away from the youth justice system
- expanding the range of community sentencing options.<sup>470</sup>

The review will also consider the legislative changes needed to increase the minimum age of detention to 14 years (as discussed in Section 5.1).<sup>471</sup>

We support the proposed review of the Youth Justice Act to achieve these purposes. We consider the review to be an opportunity to modernise the Act and include updated principles that emphasise rehabilitation, treatment and age-appropriate responses to children in the youth justice system.

Section 5 of the Youth Justice Act contains general principles that are relevant to the exercise of powers under the Act (refer to box).

### ***Youth Justice Act 1997, section 5: General principles of youth justice***

1. The powers conferred by this Act are to be directed towards the objectives mentioned in section 4 with proper regard to the following principles:
  - a. that the youth is to be dealt with, either formally or informally, in a way that encourages the youth to accept responsibility for his or her behaviour;
  - b. that the youth is not to be treated more severely than an adult would be;
  - c. that the community is to be protected from illegal behaviour;
  - d. that the victim of the offence is to be given the opportunity to participate in the process of dealing with the youth as allowed by this Act;

- e. guardians are to be encouraged to fulfil their responsibility for the care and supervision of the youth and should be supported in their efforts to fulfil this responsibility;
  - f. guardians should be involved in determining the appropriate sanction as allowed by this Act;
  - g. detaining a youth in custody should only be used as a last resort and should only be for as short a time as is necessary;
  - h. any sanctioning of a youth is to be designed so as to give him or her an opportunity to develop a sense of social responsibility and otherwise to develop in beneficial and socially acceptable ways;
  - i. any sanctioning of a youth is to be appropriate to the age, maturity and cultural identity of the youth;
  - j. any sanctioning of a youth is to be appropriate to the previous offending history of the youth.
2. Effect is to be given to the following principles so far as the circumstances of the individual case allow:
- a. compensation and restitution should be provided, where appropriate, for victims of offences committed by youths;
  - b. family relationships between a youth, the youth's parents and other members of the youth's family should be preserved and strengthened;
  - c. a youth should not be withdrawn unnecessarily from his or her family environment;
  - d. there should be no unnecessary interruption of a youth's education or employment;
  - e. a youth's sense of racial, ethnic or cultural identity should not be impaired;
  - f. an Aboriginal youth should be dealt with in a manner that involves his or her cultural community.

The current youth justice principles recognise, to some extent, that children are to be treated differently from adults in the criminal justice system, that responses to children must consider a child's age and that children's relationships with family members are important. However, we agree with Tasmania Legal Aid that the principles also place 'a heavy emphasis on sanction and punishment, rather than rehabilitation, restoration, and reintegration'.<sup>472</sup>

We consider that an updated Youth Justice Act should include principles that reflect contemporary understandings of effective youth justice systems. For example, in New Zealand, the *Oranga Tamariki Act 1989* (NZ) ('Oranga Tamariki Act') includes general principles that apply to care and protection proceedings and youth justice proceedings.<sup>473</sup> These principles are closely aligned with international human rights instruments covering children and include the following:<sup>474</sup>

- The wellbeing of a child or young person must be at the centre of decision making that affects them.
- The child or young person's rights must be respected and upheld and the child or young person must be treated with dignity and respect at all times.
- The child or young person's need for a safe, stable and loving home should be addressed.
- A child or young person must be encouraged and assisted, wherever practicable, to participate in and express their views about any proceeding, process or decision affecting them, and their views should be taken into account.
- A holistic approach should be taken that sees the child or young person as a whole person, including their developmental potential, educational and health needs, cultural identity, gender identity, sexual orientation, age and any disability.
- The primary responsibility for caring for and nurturing the wellbeing and development of the child or young person lies with their family and cultural group and, wherever possible, those relationships should be strengthened and maintained.
- The child or young person's place within their community should be recognised and the impact of a decision on the stability of a child or young person (including the stability of their education and of their connections to community) should be considered.<sup>475</sup>

The Oranga Tamariki Act also lists additional principles to be applied in exercising youth justice powers.<sup>476</sup> These include:

- Unless the public interest requires otherwise, criminal proceedings should not be instituted against a child or young person if there is an alternative means of dealing with the matter.
- A child or young person who commits an offence or is alleged to have committed an offence should be kept in the community so far as that is practicable and consonant with the need to ensure the safety of the public.
- A child or young person's age is a mitigating factor in determining whether to impose sanctions in respect of offending by a child or young person and the nature of any such sanctions.



- Any sanctions imposed on a child or young person who commits an offence should take the least restrictive form that is appropriate in the circumstances and take the form that is most likely to promote their development within their family and cultural group.
- Any measures for dealing with offending by a child or young person should, as far as practicable, address the causes underlying their offending.<sup>477</sup>

In addition, the Oranga Tamariki Act requires a court or person exercising powers in relation to youth justice to weigh four ‘primary considerations’—these are the wellbeing and best interests of the child or young person, the public interest, the interests of any victim, and the accountability of the child or young person for their behaviour.<sup>478</sup>

We consider that the updated Tasmanian youth justice legislation should include similar principles that reflect contemporary understandings of child development, children’s antisocial behaviour and children’s needs. These principles should apply to the exercise of any power under the new legislation, including sentencing, which is discussed in more detail in Section 5.5.

## Recommendation 12.12

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

## 5.3 Expanding opportunities for pre-court diversion

In this section, we focus on diversionary processes that are available in Tasmania once a child or young person comes into contact with police, although we agree with the Tasmanian Commissioner for Children and Young People that:

Greater attention must be given to recognising that the concept of diversion ... can and should begin *before* contact with police and *before* an offence or harmful behaviour has occurred ... There are a range of non-government organisations that do, and can, play an important role in providing diversionary options for children and young people in this area. This needs to be better recognised and appropriately resourced.<sup>479</sup>

According to the United Nations Committee on the Rights of the Child:

- Measures that divert children from the formal criminal justice system (and avoid resorting to judicial proceedings) ‘should be the preferred manner of dealing with children in the majority of cases’ because such measures avoid stigmatising children, produce positive results for them, are cost-effective and are ‘congruent with public safety’.<sup>480</sup>

- ‘Opportunities for diversion should be available as early as possible after [initial] contact with the [criminal justice] system, and at various stages throughout the process’.<sup>481</sup>
- ‘States parties should continually extend the range of offences for which diversion is possible, including serious offences where appropriate’.<sup>482</sup>

Currently, a child or young person who is alleged to have committed an offence in Tasmania may be eligible for diversion from the criminal justice system under the Youth Justice Act by means of an informal caution, a formal caution or a community conference.<sup>483</sup> We discuss each of these mechanisms in the following sections. There is also a school-based process for ‘informal diversion for unlawful occurrences on school grounds within the behaviour management response of schools’.<sup>484</sup>

A child or young person who is alleged to have committed a ‘prescribed offence’ under the Youth Justice Act is not eligible for diversion.<sup>485</sup> Prescribed offences are offences in respect of which the Magistrates Court (Youth Justice Division) does not have jurisdiction, and which are instead determined by the Supreme Court or the Magistrates Court’s adult jurisdiction.<sup>486</sup> A child or young person found guilty of a prescribed offence by an adult court can be sentenced under the *Sentencing Act 1997*—including to a term of imprisonment—or the Youth Justice Act.<sup>487</sup>

For all children and young people, murder, manslaughter and attempted murder are prescribed offences.<sup>488</sup> Also:

- for children or young people aged 14 years or older, prescribed offences include rape, aggravated sexual assault, persistent sexual abuse of a child, armed robbery and aggravated armed robbery<sup>489</sup>
- for young people aged 17 years, prescribed offences also include driving offences such as negligent driving causing death or serious injury, reckless driving, drink driving, drug driving and offences for excessive noise or smoke for vehicles and racing a vehicle.<sup>490</sup>

We note that this is an extensive list of offences, not all of which can be described as serious. For example, the offence of operating a vehicle ‘in a manner that emits unnecessary and unreasonable noise’, ‘in an unnecessary execution of speed’ or ‘in a race against another vehicle’ is punishable by a maximum penalty of imprisonment for three months and/or a fine.<sup>491</sup> It is unclear why a young person alleged to have committed this offence should be automatically excluded from diversion.

For eligible offences—that is, non-prescribed offences—a child or young person can only be diverted under the Youth Justice Act where they admit to committing the alleged offence.<sup>492</sup>

### 5.3.1 Informal caution

Where a police officer believes that a matter ‘does not warrant any formal action’ under the Youth Justice Act (and the child or young person admits to committing the offence), the officer may informally caution the child or young person against further offending, and no more proceedings may take place in respect of the matter.<sup>493</sup>

The Tasmania Police Manual states that children and young people must not be informally cautioned for ‘any assault’.<sup>494</sup>

### 5.3.2 Formal caution

Where a police officer believes that a matter warrants a more formal action than an informal caution, the officer may require that the child or young person be formally cautioned against further offending.<sup>495</sup> The main difference between an informal caution and a formal caution is that the police officer may require the child or young person to enter an undertaking as part of a formal caution (described below), whereas this is not available for informal cautions.<sup>496</sup>

The Youth Justice Act specifies various procedural requirements that must be met before a formal caution may be issued—these include a requirement that the police officer explains to the child or young person that they are entitled to legal advice and to have the matter dealt with in court.<sup>497</sup> A formal caution cannot be administered unless the child or young person agrees to the caution.<sup>498</sup>

Where the child or young person to be cautioned is Aboriginal, the formal caution must, ‘if practicable’, be administered by an Elder of an Aboriginal community or a representative of a ‘recognised Aboriginal organisation’ in the presence of an authorised police officer.<sup>499</sup>

As part of a formal caution, the police officer may require the child or young person to enter into an undertaking to apologise to the victim, perform community service, pay compensation, make restitution or ‘do anything else that may be appropriate in the circumstances’.<sup>500</sup>

Police keep a record of formal cautions and a formal caution may be treated as evidence of the commission of an offence by a police officer, community conference or court if the child or young person has to be dealt with for a subsequent offence.<sup>501</sup>

### 5.3.3 Community conference

Where a police officer believes that a matter warrants a more formal action than an informal caution, the officer may, as an alternative to a formal caution, require the Secretary of the Department for Education, Children and Young People to convene a ‘community conference’ to deal with the matter.<sup>502</sup> A community conference cannot be convened unless the child or young person signs an undertaking to attend the conference.<sup>503</sup>

A community conference includes a facilitator, the child or young person and their guardians, any relative or other person with a close association to the child or young person who may be able to participate usefully in the conference, any victim(s) of the offence, the police officer who initiated the conference and a youth justice worker.<sup>504</sup> Where the child or young person is Aboriginal, an Aboriginal Elder or another representative of the child or young person's community must be invited to attend the conference.<sup>505</sup>

The Youth Justice Act does not specify the purpose or aim of a community conference, but it would appear to be to decide 'an appropriate sanction' for a child or young person.<sup>506</sup> A community conference may impose one or more sanctions on the child or young person, including:

- requiring the child or young person to apologise to the victim, perform community service or pay compensation to the victim for any injury suffered or any damage to property
- administering a caution to the child or young person, or
- requiring the child or young person to 'enter into an undertaking to do anything else that may be appropriate in the circumstances'.<sup>507</sup>

A child or young person cannot be prosecuted for the offence if they perform their obligations arising from the undertakings decided by the community conference.<sup>508</sup>

### 5.3.4 Declining rates of diversion in Tasmania

Data published by the Productivity Commission in its *Report on Government Services* indicates a downward trend in the use of diversion in Tasmania.<sup>509</sup> Overall, youth diversions (including informal cautions) as a proportion of alleged youth offenders aged 10 to 17 years fell from 52 per cent in 2012–13 to 43.3 per cent in 2021–22.<sup>510</sup> For Aboriginal children and young people, youth diversions as a proportion of alleged offenders decreased substantially from 45 per cent in 2012–13 to 22.5 per cent in 2021–22.<sup>511</sup> The Productivity Commission does not provide data on separate categories of diversion.

In 2021, the Sentencing Advisory Council reported that data from Tasmania Police showed a reduction between 2010–11 and 2018–19 in the proportion of youth files diverted, with reductions in the use of informal cautions and community conferences, and a corresponding increase in the proportion of briefs sent to prosecution.<sup>512</sup>

The Sentencing Advisory Council identified the following possible reasons for the decline in diversions over time:

- the involvement of schools for lower-level offending behaviour (presumably resulting in fewer low-level matters reaching the attention of police)<sup>513</sup>

- a decline in the overall number of young offenders, together with ‘a corresponding concentration on a smaller cohort of more frequent youth offenders’, meaning that matters escalated through the system more quickly<sup>514</sup>
- a “class” factor’, whereby the response of young people to police, and parental attitudes and support, may influence the use (or non-use) of diversion by police<sup>515</sup>
- the perception among some children and young people with knowledge of the youth justice system that there were likely to be ‘harsher results’ from the undertakings imposed through formal cautions and community conferences than from outcomes in the Magistrates Court<sup>516</sup>
- the absence of diversion programs across Tasmania.<sup>517</sup>

In relation to parental support for diversion, Commissioner McLean has observed that:

... the current model assumes a support network exists around the child or young person that is resourced to be able to support the child to lead a different lifestyle. For many children and young people, this is simply not their reality ... a family which has multiple risk factors may find it very difficult to support a young person through a diversionary process without strong support.<sup>518</sup>

Children and young people who do not have a family support network—for example, children and young people under the guardianship of the State—may not be able to access diversion for these reasons.

Commissioner McLean has also noted that the discretionary nature of diversion under the Youth Justice Act ‘can result in variation between individual police officers, and regions’.<sup>519</sup>

### 5.3.5 The need for more diversion programs

The 2016 *Custodial Youth Justice Options Paper* produced by Noetic Solutions found that Tasmania did not have the ‘breadth or depth’ of diversionary services required to address the complex needs of children and young people.<sup>520</sup> More recently, Tasmania Legal Aid has advocated for diversionary programs to be made available in rural and regional areas of Tasmania, and for the development of ‘universal programs’ to ‘avoid the postcode injustice that flows from a patchwork of options around the State’.<sup>521</sup>

In its 2021 report on sentencing young offenders, the Sentencing Advisory Council referred to a range of programs Tasmania Police uses to support diversion by way of caution or community conference.<sup>522</sup> These include prescribed courses at the Brain Injury Association of Tasmania, the ‘Junior Fire Lighter Intervention Program’ (through the Tasmanian Fire Service), the ‘bike rebuilding program’, Men’s Shed programs and the First Tee program through the Police Citizens Youth Club.<sup>523</sup>

However, Mr Caltabiano told us that Tasmania does not have structured pre-court diversionary programs for children that apply uniformly across the State.<sup>524</sup> Children should be able to access effective diversionary programs regardless of where they live in Tasmania.

### 5.3.6 Youth justice reforms

The Draft Youth Justice Blueprint includes a significant focus on diversion. One of its principles is to ‘divert children and young people from the youth justice system wherever possible’ and Strategy 2 is to ‘ensure diversion from the justice system is early and lasting’.<sup>525</sup> The Draft Youth Justice Blueprint describes diversion as aiming to ‘provide pathways through which children and young people with limited or no criminal history and who have committed low level offences can be directed away from the justice system’.<sup>526</sup>

The Tasmanian Government’s diversion strategy aims to reduce the involvement of children and young people in the youth justice system by (among other commitments):

- providing a range of developmentally appropriate responses for children and young people under the minimum age of criminal responsibility, who are exhibiting behaviours that would otherwise be considered an offence
- providing a range of diversionary options and programs for children and young people who come into contact with the justice system
- ensuring Aboriginal children and young people have access to Aboriginal-led diversionary services
- ensuring children and young people have access to services to address their mental health, disability and alcohol and other drug dependence needs.<sup>527</sup>

Action 4 under the Government’s Draft First Action Plan includes commitments to:

- review current diversionary options to ‘identify what is working, what needs strengthening to ensure maximum impact and where there are service gaps’<sup>528</sup>
- develop a Diversionary Services Framework to ‘guide and support the delivery of a range of diversionary programs across the continuum in Tasmania’<sup>529</sup>
- engage with Aboriginal communities to ensure a range of appropriate, culturally safe and Aboriginal-led services for Aboriginal children and young people<sup>530</sup>
- deliver new diversion programs by 2025.<sup>531</sup>

In February 2023, Secretary Bullard advised us that the Department for Education, Children and Young People had begun researching diversion programs in other jurisdictions.<sup>532</sup> We note that research indicates:

While there is no ‘one size fits all’ approach to preventing youth offending, programs that have a strong theoretical basis, consider the individual needs of young people, are culturally sensitive to Indigenous Australians where relevant, and reflect on practice through iterative evaluation will be best placed to address the underlying causes of offending.<sup>533</sup>

### 5.3.7 Our recommendations

We note with concern the decreasing rates of diversion in Tasmania, particularly for Aboriginal children and young people. In Section 7.1, we recommend developing an Aboriginal youth justice strategy to examine and establish evidence-based, Aboriginal-led diversion programs for Aboriginal children and young people in contact with police (Recommendation 12.27).

We commend the Department for committing to create a Diversionary Services Framework and new diversion programs. In our view, this presents an opportunity to carefully examine the effectiveness of existing diversion processes to ensure opportunities for pre-court diversion in Tasmania can be maximised. In particular, the Government should examine the use of police discretion in referring children and young people to diversion and the use and effectiveness of undertakings imposed with formal cautions and sanctions imposed by community conferences.

The Government should also reconsider the current list of prescribed offences to ensure opportunities for pre-court diversion can be maximised. In addition, the Government should ensure prescribed offences do not exclude children engaging in harmful sexual behaviours from broader therapeutic and diversionary opportunities. We discuss other diversionary mechanisms in Chapters 16 and 21.

We note that the Commissioner for Children and Young People has advocated for repealing prescribed offences from the Youth Justice Act, so ‘all types of offences including serious offending [can] be dealt with in a trauma informed, child centred way that is consistent with best practice’.<sup>534</sup> We discuss court specialisation for children and young people in Section 5.5.4.

#### **Recommendation 12.13**

1. The Tasmanian Government, in reviewing current diversion processes and developing a Diversionary Services Framework, should:
  - a. examine the exercise of police discretion to determine whether opportunities for cautioning and community conferencing are being maximised, particularly for Aboriginal children and young people, and children and young people without a strong family support network



- b. commission research to examine the effectiveness of formal cautions imposed with undertakings and the sanctions imposed by community conferences, to ensure they are proportionate to the alleged offending and not unnecessarily onerous
  - c. introduce legislation to widen the range of alleged offences in respect of which diversion may be pursued and create a presumption in favour of pre-court diversion for children and young people.
2. The Tasmanian Government should begin statewide delivery of new diversion programs under the Diversionary Services Framework by 2025.

## 5.4 Increasing access to bail for children and young people

A child or young person whom police do not consider suitable for diversion may be arrested and charged with an offence. Police must release the child or young person on bail ‘unless there is reasonable ground for believing that such a course would not be desirable in the interests of justice’.<sup>535</sup> If police refuse bail, the child or young person must be brought before a magistrate or a justice of the peace ‘as soon as practicable’.<sup>536</sup>

During business hours, the child or young person will appear before a magistrate for a bail hearing. After hours, the child or young person will generally be brought before a ‘bench justice’—a justice of the peace who is rostered by the Chief Magistrate to deal with out of hours bail hearings (among other matters)—although magistrates can also sit out of hours at the discretion of the Chief Magistrate.<sup>537</sup> A child or young person who is refused bail by a justice of the peace is remanded into youth detention until they can be brought before the Magistrates Court (Youth Justice Division).<sup>538</sup>

A child or young person who is refused bail by a magistrate is also remanded into youth detention until the criminal charge against them is heard in court. A child or young person may also be remanded after they have been found guilty of an offence, while awaiting sentencing.

According to data published by the Australian Institute of Health and Welfare, on an average day in 2021–22, there were eight children and young people aged 10 to 17 years in detention in Tasmania and, of these, six were on remand.<sup>539</sup> In August 2022, Ms Atkins told us that 10 of the 11 children and young people held at the Ashley Youth Detention Centre at the time were on remand.<sup>540</sup> Ms Atkins described this proportion of remanded children and young people as ‘a regular occurrence’.<sup>541</sup> Other Australian jurisdictions have similarly high proportions of children and young people on remand.<sup>542</sup> In 2021–22, children and young people who were unsentenced (on remand) spent an average of 57.5 days in detention in Tasmania.<sup>543</sup>

We note that, more recently, there has been a substantial increase in the number of children and young people in detention in Tasmania. In June 2023, Commissioner McLean told us that, as at 5 June 2023, there were 21 children and young people held at Ashley Youth Detention Centre, of whom 18 were on remand.<sup>544</sup>

According to Tasmania Legal Aid, 'it is commonly the case' that once the charges against a child who has been remanded are heard, 'the child is released without serving any further time in custody'.<sup>545</sup>

Research has demonstrated that remand is disruptive and harmful to children and young people and has little rehabilitative benefit.<sup>546</sup> According to the Victorian Sentencing Advisory Council, for children and young people, remand:

... can lead to separation from family and community, disruption to education and employment, association with sentenced young offenders, being held in inappropriate facilities, being unable to access therapeutic programs, having an increased chance of being placed on remand if arrested again, and having an increased chance of receiving a custodial sentence compared with young people who are granted bail.<sup>547</sup>

#### 5.4.1 Drivers of remand

We heard from victim-survivors, lawyers and policy experts that the absence of safe accommodation and support options was a key reason that children and young people were being denied bail and remanded.

Professor White referred to the 'longstanding issue' in Tasmania of remanding children and young people 'mainly due to lack of adequate housing or alternative places to put kids'.<sup>548</sup> Similarly, Mr Caltabiano told us that magistrates often wished to include a condition of bail requiring the child or young person to reside at a specific address, and that where accommodation was not available, bail was harder to obtain.<sup>549</sup>

In its submission to the former Department of Communities on proposed reforms to the youth justice system, Tasmania Legal Aid stated that:

Children in Tasmania are often refused bail because of problems with accommodation that are outside their control. This could include situations where the child is homeless, is under the care of child safety and without effective supervision, or because of mental health or drug problems.<sup>550</sup>

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, told us that children and young people with substance misuse, undiagnosed mental illness or with disability may be remanded because there were no available treatment facilities for children and young people in Tasmania.<sup>551</sup>

We also heard that whether a child or young person is granted bail may depend on whether they appear before a justice of the peace or a magistrate. Mr Caltabiano observed that children and young people refused bail by a justice of the peace at

an after-hours bail hearing were ‘commonly’ granted bail when they appeared before a magistrate the following business day.<sup>552</sup> He indicated that this may be ‘due to the Magistrates’ broader understanding of the legislative framework and greater experience dealing with young people’.<sup>553</sup>

Similarly, research undertaken by the Australian Institute of Criminology on bail and remand for children and young people in Australia described some Tasmanian stakeholders as suggesting that the bail decisions of justices of the peace tended to be ‘more punitive and risk averse in response to community attitudes towards youth crime’.<sup>554</sup> That research acknowledged that, in some jurisdictions, a more detailed case may be presented to a magistrate than to a justice of the peace and, while decisions by justices of the peace may seem punitive, it could be the case that magistrates are simply provided with more and better information with which to make decisions.<sup>555</sup> However, some stakeholders pointed to the need to educate justices of the peace on the role of bail in the criminal justice system and using detention as a last resort for children and young people.<sup>556</sup>

We also heard about the importance of legal representation for children and young people in bail hearings to minimise the risk of remand. Ms Phillips described a situation where the Tasmanian Aboriginal Legal Service appeared out of hours for an Aboriginal young person who was on a child safety order and had multiple bail conditions across several matters:

If I had not been there, the young person would have had to argue for their own bail, with only the Justice of the Peace, prosecutor, and a representative of Youth Justice present. Child Safety Service were not present at Court for the young person. The young female was ultimately bailed, but it was late at night and she had no way of getting home. If we were not there to advocate for this young person, it was highly likely she would have been remanded at Ashley Youth Detention Centre for the night ... This highlights two things; the first is the importance of representation in out of hours Court but also the need to ensure guardians or parents are actively present for young people, when possible, in out of hours Court, in this instance Child Safety Service.<sup>557</sup>

The Tasmanian Aboriginal Legal Service is not funded to appear out of hours for Aboriginal children and young people, but does appear on occasions if it is ‘particularly concerned for a young person’s welfare and [has] capacity to assist’.<sup>558</sup>

Mr Caltabiano told us that there was only one after-hours duty lawyer service (for adults and children) operating in Tasmania—this service is funded by Tasmania Legal Aid from funding allocated by the Tasmanian Government and is provided by the Hobart Community Legal Centre at the Hobart Magistrates Court on Friday evening, Saturday and Sunday.<sup>559</sup> The Tasmanian Government’s 2021–22 State Budget allocated \$320,000 over four years to provide children and young people appearing in court after hours in Burnie, Devonport and Launceston with access to a duty lawyer.<sup>560</sup>

## 5.4.2 Bail support programs

Commissioner McLean has referred to a lack of appropriately resourced bail support programs for children and young people in Tasmania.<sup>561</sup>

Non-government organisation Save the Children provides the statewide ‘Supporting Young People on Bail’ program—a voluntary program where youth workers support children and young people aged 10 to 17 years on bail ‘to achieve their recreational, educational and vocational/employment goals during their bail period and beyond’ and to avoid further interaction with the youth justice system.<sup>562</sup> In its submission to the former Department of Communities on the proposed youth justice system reforms, the Tasmanian Aboriginal Legal Service described the positive experience of an Aboriginal young person in this program, who was taken fishing on several occasions by a youth worker while on bail, which allowed them ‘to create a bond and gave the young person something to look forward to’.<sup>563</sup>

Although it is a voluntary program, a magistrate may order a mandatory meeting of the child or young person with Save the Children workers, who create a bail support plan for the child or young person.<sup>564</sup> In her 2022 submission on the proposed youth justice reforms, Commissioner McLean indicated that, in some instances, young people had been remanded for several weeks to enable bail support plans to be prepared, in circumstances where a sentence of detention may not have been imposed—a practice that she noted appeared to be contrary to the aim of using detention as a last resort.<sup>565</sup>

Previously, the Save the Children bail support program was not available for children and young people with child protection involvement, but it is not clear whether this is still the case.<sup>566</sup> Bail support programs should be widely available to children and young people, regardless of their involvement with other service systems.

The Commissioner for Children and Young People, Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service have all advocated to expand bail support programs in Tasmania.<sup>567</sup> Commissioner McLean and Tasmania Legal Aid have indicated that this should include bail support workers who can coordinate support services and access brokerage funds for accommodation.<sup>568</sup>

## 5.4.3 Conditions of bail

Section 24B of the Youth Justice Act provides that a magistrate, justice of the peace or police officer who intends to admit a child or young person to bail must consider the youth justice principles in section 5 of the Act (extracted in Section 5.2) in deciding whether to impose any conditions of bail.<sup>569</sup>

Despite this provision, Commissioner McLean has drawn attention to the difficulties for many children and young people in complying with bail conditions requiring them to:

- submit to a curfew—such conditions can be particularly problematic for young people who are couch surfing, living in unstable accommodation or are otherwise at risk of homelessness
- not attend particular venues or locations—such conditions may restrict young people’s access to essential areas such as bus terminals and supermarkets
- report to police or youth justice workers—such conditions can pose difficulties for young people due to a lack of transport and other practical challenges.<sup>570</sup>

Similarly, the Tasmanian Aboriginal Legal Service has indicated that children and young people on bail may have difficulty keeping a mobile phone charged or maintaining mobile phone credit, which can be a barrier to accessing support services:

In many instances, our lawyers are aware referrals have been made to support services for a young person but then they are non-contactable, leading to the referral being closed. This can mean little progress is made during adjournment periods in court to support and rehabilitate young people ... [which] ultimately increase[s] the chance of young people ending up in detention.<sup>571</sup>

In the absence of coordinated and consistent support, such as support to get to appointments, children and young people may breach their conditions of bail and be remanded in custody.

#### 5.4.4 Child-specific bail laws

With the exception of section 24B of the Youth Justice Act (outlined in Section 5.4.3), children and young people in Tasmania are essentially subject to the same legislation as adults in terms of bail.

Mr Caltabiano advocated for Tasmania adopting child-specific bail laws similar to those in Victoria.<sup>572</sup> Section 3B of the *Bail Act 1977* (Vic) states that, in making a determination under the Act, a bail decision maker must take into account:

- the need to consider all other options before remanding the child in custody
- the need to strengthen and preserve the relationship between the child and the child’s family, guardians or carers
- the desirability of allowing the living arrangements of the child to continue without interruption or disturbance
- the desirability of allowing the education, training or employment of the child to continue without interruption or disturbance
- the need to minimise stigma to the child resulting from being remanded in custody
- the likely sentence should the child be found guilty of the offence charged

- the need to ensure the conditions of bail are no more onerous than are necessary and do not constitute unfair management of the child.<sup>573</sup>

The *Bail Act 1977* (Vic) also provides that:

- ‘bail must not be refused to a child on the sole ground that the child does not have any, or any adequate, accommodation’<sup>574</sup>
- where a bail decision maker has to consider the ‘surrounding circumstances’, this must include ‘any special vulnerability of the accused, including being a child or an Aboriginal person, being in ill health or having a cognitive impairment, an intellectual disability or a mental illness’.<sup>575</sup>

We note that, despite these provisions, the number of children and young people on remand on an average day in Victoria doubled between 2010 and 2019.<sup>576</sup> While child-specific bail laws alone are not sufficient to prevent or address concerning high numbers of children and young people on remand, we see them as an important part of reducing remand numbers.

In 2021, the Tasmanian Government consulted on a draft Bail Bill, which did not include child-specific provisions for making bail determinations.<sup>577</sup> The Commissioner for Children and Young People expressed concerns about the likely impact of the Bill on children and young people in Tasmania.<sup>578</sup> At the time of writing, the Bail Bill 2021 had not been introduced into the Tasmanian Parliament.

#### 5.4.5 Youth justice reforms

The Draft Youth Justice Blueprint:

- acknowledges that appropriate bail support options, including accommodation options, are needed to avoid unnecessary detention<sup>579</sup>
- acknowledges that all other states and territories have some form of statewide bail assistance program, which includes three common key components—an after-hours support service, bail supervision and accommodation support<sup>580</sup>
- indicates that the Government aims to reduce the number of children and young people re-entering the youth justice system by ‘delivering effective support that meets the individual needs and circumstances of children and young people on bail through a range of assisted bail options’.<sup>581</sup>

As noted in Section 2, the Government has committed to establishing two assisted bail facilities to:

... provide safe stable accommodation, assistance managing bail conditions and support to address underlying issues that are contributing towards harmful, antisocial or offending behaviours.<sup>582</sup>

Information released by the Government on the proposed assisted bail facilities indicates that they will:

- be managed by the Government or a non-government organisation
- be ‘semi secure to encourage compliance noting that [the] young person is not legally bound to stay there unless [this is a] condition of bail’
- have individual self-contained units, with one support and administration unit for staff and ‘some recreational spaces’
- be targeted at young people who are ‘likely to have no suitable bail address and/or require support for mental health, drug and alcohol, etc.’, with charges for offences ‘likely to be non-violent/lower seriousness’, and who are unlikely to receive a custodial sentence if found guilty
- be available to a young person who is granted bail by a magistrate or a justice of the peace, including in situations where the young person has previously been remanded, and where the young person would otherwise not have been remanded but ‘the extra support is warranted’
- have ‘24/7 onsite support provided by Government or [a non-government organisation]’.<sup>583</sup>

The Government advised us that ‘the use of the term semi-secure in the proposed facilities model refers to the need to limit those who enter the facility to ensure the safety of all people onsite’.<sup>584</sup> We note that this is not entirely consistent with the above reference to ‘encourag[ing] compliance’.

In February 2023, Secretary Bullard told us that planning consultants had been engaged to identify suitable sites across the State to accommodate all of the proposed new youth justice facilities (including the assisted bail facilities) and that an action plan for delivering the new infrastructure had been developed, with ‘visioning’ workshops scheduled for February 2023.<sup>585</sup>

#### 5.4.6 Our recommendations

The high proportion of children on remand in Tasmania is extremely concerning. Remand should only be used in the most serious cases, where the child or young person poses an immediate danger to others, ‘and even then only after community placement has been carefully considered’.<sup>586</sup> It must only be used as a measure of last resort and for the shortest possible period.<sup>587</sup>

We commend the Government for its intention to establish assisted bail facilities that will involve 24-hour onsite support for children and young people, including mental health and drug and alcohol support. We recommend that these facilities:



- have the capacity to deal with children and young people with complex needs
- include wraparound services such as health, education and employment
- engage specialist, therapeutically trained bail support workers to help children and young people attend programs and services, and to comply with conditions of bail.

Also, these facilities must be culturally safe for Aboriginal children and young people (cultural safety is discussed in Section 7.3).

To ensure they do not become de facto remand centres, children and young people should not be prevented from leaving the assisted bail facilities (subject to any conditions of bail).

The size of the proposed assisted bail facilities has not yet been specified, but they are unlikely to accommodate every child or young person on bail who needs support. While we did not receive any evidence about the statewide Supporting Young People on Bail program run by Save the Children, we note that the Tasmanian Aboriginal Legal Service is supportive of this program. As part of its youth justice reforms, the Government should examine the effectiveness of this program, consider the appropriateness of its eligibility criteria, and determine whether it needs increased funding, so more children and young people can be assisted with more intensive support, or whether additional bail support programs should be established.

The fate of a child or young person should not depend on whether their bail hearing occurs during business hours or after hours, or whether they appear before a magistrate or a justice of the peace. We recommend that the Government establishes a statewide 24-hour bail system for children and young people with bail decision makers (whether magistrates or justices of the peace) who have received specialist training in child development, trauma and disability (including communication deficits), and the issues faced by many Aboriginal children and young people, to ensure a consistent, trauma-informed and child-focused approach to decision making. Specialist training should contribute to ensuring bail conditions for children and young people are not unnecessarily onerous.

Children and young people should have access to legal representation in after-hours bail hearings. The bail system should also include access to bail support services after hours.

In Chapter 9, we recommend that, for children in out of home care, their child safety officer or another departmental representative with knowledge of the child attends any criminal proceedings involving the child in their role as the child's legal guardian, responsible for the child's care and protection (Recommendation 9.27). This should include bail hearings.

Finally, we recommend introducing child-specific bail laws that clearly outline the relevant considerations for bail decision making for children and young people.

## Recommendation 12.14

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

- a. introduce legislation to
  - i. require bail decision makers to consider the matters specified in section 3B of the *Bail Act 1977* (Vic) when determining bail for a child, as well as the child's age (including their developmental age at the time of the alleged offence), Aboriginal status and any previous experience of trauma or out of home care
  - ii. prohibit the refusal of bail to a child on the sole ground that the child does not have any, or any adequate, accommodation
- b. examine the effectiveness of the existing bail support program with a view to expanding its capacity and funding additional bail support programs
- c. establish and fully resource a statewide 24-hour bail system for children and young people with
  - i. specialised and trained decision makers who have knowledge of children and young people, Aboriginal children and young people, and the impact of trauma
  - ii. access to corresponding bail support services
  - iii. access to legal representation for children and young people
- d. ensure its proposed assisted bail facilities
  - i. are small, homelike and, subject to bail conditions, do not place restrictions on the movements of children and young people
  - ii. have the capacity to deal with children and young people with complex needs
  - iii. are designed to include wraparound services, such as health, education and employment
  - iv. are culturally safe for Aboriginal children and young people
  - v. include specialist, therapeutically trained bail support workers to help children and young people attend programs and services, and to comply with their conditions of bail.

## 5.5 Ensuring detention is a sentence of last resort

According to the Committee on the Rights of the Child, youth justice laws:

... should contain a wide variety of non-custodial measures and should expressly prioritize the use of such measures to ensure that deprivation of liberty is used only as a measure of last resort and for the shortest appropriate period of time.<sup>588</sup>

### 5.5.1 Tasmania's sentencing framework

If a child or young person is found guilty of an offence by the Magistrates Court (Youth Justice Division), the court must sentence the child or young person under the Youth Justice Act, defer sentencing or make an order that the child or young person attend a community conference convened by the Secretary of the Department for Education, Children and Young People.<sup>589</sup>

Section 47 of the Youth Justice Act lists sentencing orders that the court may impose. These are not expressed or described as a hierarchy. The court can:<sup>590</sup>

- dismiss the charge and impose no further sentence<sup>591</sup>
- dismiss the charge and 'reprimand' (formally warn) the child or young person<sup>592</sup>
- dismiss the charge and require the child or young person to enter into an undertaking to 'be of good behaviour'—this is a form of conditional, unsupervised release where the child or young person undertakes to do or refrain from doing acts specified in the undertaking for a period of no more than six months<sup>593</sup>
- release the child or young person and adjourn the proceedings on conditions—sentencing is postponed for a period of no more than 12 months on conditions set out by the court that must be 'reasonable in the circumstances'<sup>594</sup>
- impose a fine—maximum amounts vary depending on the age of the child or young person<sup>595</sup>
- make a probation order—this is an order supervised by a youth justice worker requiring the child or young person to report to, receive visits from and obey the instructions of the youth justice worker, and to comply with any 'special conditions' specified in the order, including attending school or rehabilitation programs, abstaining from drinking alcohol or using drugs, residing at a specified address, submitting to a curfew and undergoing drug counselling and treatment<sup>596</sup>
- make a community service order—this is an order requiring the child or young person to perform a 'community service activity' approved by the Secretary and assigned by a youth justice worker, and to comply with special conditions like those available for probation orders<sup>597</sup>

- make a detention order not exceeding two years—the court may also order that part or all of the period of detention be ‘suspended’ (enabling the child or young person to be released), subject to conditions including reporting to a youth justice worker, attending programs directed by the worker, submitting to drug and alcohol testing, as well as any special conditions that the court imposes<sup>598</sup>
- in the case of a family violence offence, make a rehabilitation program order—this is an order to attend and take part in a rehabilitation program and comply with the reasonable directions of a person employed or engaged to conduct such a program<sup>599</sup>
- adjourn the proceedings, grant bail to the child or young person and defer sentencing until a date specified in the order, for the purpose of assessing the capacity of the child or young person and their prospects for rehabilitation, allowing them to participate in an ‘intervention plan’ or for other purposes.<sup>600</sup>

Alternatively, as noted, instead of sentencing the child or young person, the court can order that the child or young person attends a community conference convened by the Secretary.<sup>601</sup> The procedure for the community conference is similar to the procedure for pre-court diversionary community conferences (discussed in Section 5.3.3).<sup>602</sup> If the child or young person fulfils all the undertakings entered into at the community conference, the court will dismiss the charge against the child or young person.<sup>603</sup>

In determining what sentencing order to make, the court must:

- ensure the rehabilitation of the child or young person is ‘given more weight than is given to any other individual matter’<sup>604</sup>
- consider all the circumstances of the case, including the nature of the offence, the child or young person’s age, any sentences or sanctions previously imposed on them and the ‘impact any orders made will have on the youth’s chances of finding or retaining employment or attending education and training’<sup>605</sup>
- not impose a sentence that is more severe than would be imposed on an adult who committed the same offence.<sup>606</sup>

Sentencers must also consider the ‘general principles of youth justice’ contained in section 5 of the Youth Justice Act (set out in Section 5.2 of this chapter). While most of these principles are potentially relevant to sentencing, we note in particular the following:

- Detention should only be used as a last resort and only for as short a time as necessary.<sup>607</sup>
- Any sanctioning is to be appropriate to the age, maturity and cultural identity of the child or young person.<sup>608</sup>

- Any sanctioning is to be designed to give a child or young person an opportunity to develop a sense of social responsibility and otherwise to develop in beneficial and socially acceptable ways.<sup>609</sup>

The Youth Justice Act does not explicitly require sentencers to consider any trauma or disadvantage experienced by the child or young person, although one of the objectives of the Act is to ensure that, ‘whenever practicable, a youth who has committed, or is alleged to have committed, an offence is dealt with in a manner that takes into account the youth’s social and family background’.<sup>610</sup> Trauma-informed sentencing is discussed in Section 5.5.3.

### 5.5.2 Sentencing children and young people in Tasmania

In October 2021, the Tasmanian Sentencing Advisory Council published a report on the sentencing of children and young people in Tasmania between 2014–15 and 2019–20.<sup>611</sup> The Sentencing Advisory Council found that, during this period:

- 90.7 per cent of sentencing orders made under the Youth Justice Act were non-custodial<sup>612</sup>
- the most frequently used sentencing order was ‘release on conditions’ (26 per cent)<sup>613</sup>
- supervised orders (probation and community service orders) accounted for 24 per cent of all sentencing orders<sup>614</sup>
- detention or suspended detention accounted for 9 per cent of sentencing orders.<sup>615</sup>

Data published by the Australian Institute of Health and Welfare indicates that there were 57.3 children and young people aged 10 to 17 years under community-based youth justice supervision in Tasmania on an average day in 2021–22, compared with 8.1 children and young people aged 10 to 17 years in youth detention on an average day in the same period.<sup>616</sup>

The number of children and young people under community-based youth justice supervision in Tasmania has decreased since 2012–13, when there were 144.9 children and young people aged 10 to 17 years under community-based supervision on an average day.<sup>617</sup> Despite this reduction, Tasmania has the fourth-highest rate of children and young people under community-based youth justice supervision after the Northern Territory, Queensland and Western Australia.<sup>618</sup>

According to Mr Caltabiano, ‘[i]t is a small step to go from a formal supervisory order to detention’.<sup>619</sup> This comment may refer to the fact that a child or young person who breaches a supervised sentencing order is at risk of being resentenced to detention.

Former Noetic Solutions consultant, Anthony McGinness, who has expertise reviewing youth justice systems nationally, told us that when the Tasmanian Government commissioned him to examine the custodial youth justice system in Tasmania in 2016, he observed the absence of a ‘graduated model’ in sentencing (which would give young people opportunities to be diverted from detention).<sup>620</sup> Mr McGinness referred instead to a ‘blunt jump’ between the sentencing options available and detention:

From my experience working in youth justice, an ideal model would involve incremental steps in sentencing – however, young people at Ashley Youth Detention Centre were less likely to have been given these diversionary options, and more likely to quickly progress from warnings to custody. There are complex factors behind this, and it was not the primary focus of our analysis, but this is likely contributed to by the availability of alternatives and options, and practice by police and the justice system.<sup>621</sup>

We did not receive any specific evidence on the use of non-custodial sentencing orders under the Youth Justice Act, or the operation of Community Youth Justice (the area of the Department responsible for diversion and rehabilitation programs for young people under youth justice supervision in the community).<sup>622</sup> However, we note that the Youth Justice Act lists a range of community-based sentencing options for children and young people, all of which appear to be in use.<sup>623</sup> Without an analysis of the sentencing histories of individual children and young people, it is difficult to assess whether Mr McGinness’s comment about the ‘blunt jump’ to detention is accurate. Nevertheless, we consider that there is scope to amend the Youth Justice Act to make it clearer that detention must be an option of last resort.

Also, we note that the Sentencing Advisory Council referred in its 2021 report to the absence of services to support conditions attached to community-based sentencing orders:

In stakeholder consultations, concern was raised about the lack of services to support the conditions made in orders imposed by the court. There may not be the appropriate services at all or wait lists may be too long to allow the young person to access the program or service in a timely way.<sup>624</sup>

An effective youth justice system must deliver targeted therapeutic services to support community-based sentencing, including community-based education programs. An example is the Ignatius Learning Centre in Melbourne—a Catholic specialist secondary school operated by Jesuit Social Services for young men aged 15 to 17 years who are involved in the youth justice system and are disengaged, or at risk of disengaging, from education.<sup>625</sup> This program is available to young men who are being considered for a supervised community-based sentencing order (such as a youth supervision order or a youth control order) under the *Children, Youth and Families Act 2005* (Vic) or who are on remand and facing a custodial sentence.<sup>626</sup> Attendance at the Ignatius Learning Centre may become a condition of the sentencing order.<sup>627</sup> The Ignatius Learning Centre

‘provides a safe, holistic and therapeutic learning environment’ and supports its students to complete the Victorian Certificate of Applied Learning.<sup>628</sup>

As well as the need for therapeutic services, the Commissioner for Children and Young People has, as discussed in Section 5.4.3, expressed concerns about attaching curfew conditions, reporting conditions and non-attendance conditions to bail orders. We note that similar concerns could apply to the conditions of community-based sentencing orders.

### 5.5.3 Trauma-informed sentencing

Between June 2019 and June 2020, the Victorian Sentencing Advisory Council published three reports on ‘crossover kids’, whom it defined as children who have been sentenced or diverted through the justice system and are also known to the Victorian Child Protection Service.<sup>629</sup> This research identified that children known to child protection were substantially over-represented among sentenced and diverted children, and Aboriginal children were ‘substantially over-represented at the intersection of the child protection and youth justice systems’.<sup>630</sup>

These findings are broadly consistent with research published by Tasmania Legal Aid in its 2021 *Children First* report.<sup>631</sup> Tasmania Legal Aid found that, while only 10 per cent of its child clients who had a child safety file also had a youth justice file (defined in the report as ‘crossover children’), crossover children accounted for 24 per cent of all youth justice files, and each crossover child had close to twice as many youth justice files as other children in the youth justice system.<sup>632</sup> Fifteen per cent of crossover children identified as Aboriginal.<sup>633</sup> Forty-one per cent of children first charged with an offence before the age of 14 years were crossover children.<sup>634</sup> In Chapter 9, we discuss the substantial crossover between children in out of home care and children in detention in Tasmania.

In its third report on crossover children, the Victorian Sentencing Advisory Council considered the sentencing of children who have experienced trauma, finding that:

There is now broad consensus that trauma can affect children’s neurological, psychological and even physical development. Children are particularly vulnerable to the effects of trauma: their brains are still developing, and trauma can interrupt or alter that process. In this context, trauma becomes a particularly relevant factor to consider in sentencing. It affects children’s culpability, their ability to comply with court-ordered conditions and their capacity to be rehabilitated ...<sup>635</sup>

In light of its research, the Victorian Sentencing Advisory Council suggested a range of other matters which courts should consider in sentencing children and young people in Victoria.<sup>636</sup> These included the child’s experience of trauma; any child protection involvement; removal of the child from their family of origin (including siblings, extended family, culture and community); disruptions to the child’s living situation or education;



any experience of out of home care; mental illness, neurological difficulties and developmental issues arising from, or exacerbated by, experiences of trauma; and the child's chronological age and developmental age at the time of sentencing.<sup>637</sup>

The Victorian Sentencing Advisory Council also suggested other considerations relevant to sentencing Aboriginal children, namely the consequences of intergenerational trauma; historical discriminatory policies; general and systemic racism; and any relevant cultural factors such as previous culturally inappropriate responses to Aboriginal children that may have worsened the effects of trauma.<sup>638</sup>

In addition, the Victorian Sentencing Advisory Council proposed several practical measures to reduce the over-representation of crossover children in the Criminal Division of the Children's Court and 'to strengthen the capacity of sentencing courts to be fully appraised of a child's [child] protection history and experience of trauma'.<sup>639</sup>

These measures included:

- strengthening information sharing between the Family Division (which deals with child protection matters) and the Criminal Division of the Children's Court
- introducing a 'crossover list' in the Children's Court that would deal with the child protection and criminal matters of children involved in both systems
- providing dedicated child protection workers in the Criminal Division to facilitate access to reports about a young person's child protection history
- empowering the Criminal Division to compel child protection case workers to attend court and/or support a child in cases where the Secretary of the Department of Health and Human Services has parental responsibility for the child.<sup>640</sup>

As noted, in Chapter 9, we recommend that, in its role as guardian of a child in care responsible for the child's care and protection, the Department for Education, Children and Young People ensures a child safety officer or other departmental representative with knowledge of the child attends any criminal proceedings against the child in the Magistrates Court to support them in court and to inform the court of the child's background and child protection history (Recommendation 9.27). For the purposes of sentencing, this would give the court an understanding of any previous trauma the child has experienced. We consider court specialisation in the following section.

#### **5.5.4 Court specialisation for children and young people**

According to the United Nations Committee on the Rights of the Child, the 'continuous and systematic training of professionals in the child justice system is crucial' to uphold the guarantees in the Convention on the Rights of the Child that every child receives a fair trial.<sup>641</sup> Such professionals should be 'well informed about the physical, psychological, mental and social development of children and adolescents, as well as about the special needs of the most marginalized children'.<sup>642</sup>

As noted, the Youth Justice Division of the Magistrates Court deals with most criminal charges against children and young people. A single magistrate in each registry hears all youth justice matters.<sup>643</sup> Also, the Youth Justice Division maintains a ‘specialist list’ of cases involving children and young people ‘with alcohol and drug abuse, mental health problems, or any other particular problem or combination of problems where the Court might appropriately intervene’.<sup>644</sup> According to the Sentencing Advisory Council, the Youth Justice Division adopts a therapeutic, strengths-based, collaborative and ‘largely non-adversarial’ approach, with coordination and cooperation between the various agencies involved in the youth justice system.<sup>645</sup>

The Children’s Division of the Magistrates Court, also referred to as the ‘Children’s Court’, deals with child protection matters.<sup>646</sup> Professor White told us that there were two magistrates who are designated as Children’s Court magistrates and who are ‘essentially specialist magistrates’.<sup>647</sup> However, Commissioner McLean told us that she is not aware of any specialisation in respect of the Children’s Division, and that—other than those magistrates who may be recused (unable to hear a matter) due to a conflict of interest—all magistrates deal with Children’s Division matters statewide.<sup>648</sup>

The Magistrates Court does not appear to have a specific ‘crossover list’ for children and young people with criminal matters who also have child protection involvement. Commissioner McLean told us that where a child or young person is the subject of both child protection and youth justice proceedings:

... different magistrates, in different courtrooms, may deal with each matter, which results in low confidence that the courts have a shared or consistent view on how best to address the offending behaviour and child protection needs of the young person.<sup>649</sup>

As noted in Section 5.3, charges for prescribed offences against children and young people are dealt with in the Supreme Court or the Magistrates Court’s adult jurisdiction, and sentencing for such offences may occur under the *Sentencing Act 1997* rather than the Youth Justice Act. In 2021, the Sentencing Advisory Council observed that:

The low number of youth offenders sentenced in the Supreme Court has [a] bearing on infrastructure provision as well as the level of specialist knowledge of judges in dealing with young people.<sup>650</sup>

Some stakeholders consulted by the Sentencing Advisory Council expressed the view that ‘the process in the Supreme Court generally treats children as “mini adults”’.<sup>651</sup>

Professor White said he would value ‘more therapeutic oriented judges and magistrates in Tasmania who are specially trained, fostered by specialist court divisions that could support this’.<sup>652</sup>

Despite the existence of a Children’s Division and a Youth Justice Division in the Magistrates Court, Tasmania Legal Aid has described Tasmanian courts as ‘imposing,

adult environments’ where ‘[i]t is common for children to be waiting for their case in the same area with adults charged with criminal offences’.<sup>653</sup> Tasmania Legal Aid has advocated for establishing a separate, standalone Children’s Court in Tasmania to deal with youth justice and child protection matters.<sup>654</sup> Mr Caltabiano said that a specialist Children’s Court should be physically designed for children and staffed by dedicated magistrates.<sup>655</sup>

The Commissioner for Children and Young People has also indicated that ‘serious consideration should be given to establishing a standalone Children’s Court in Tasmania with jurisdiction to hear all matters involving children and young people’, including charges for prescribed offences.<sup>656</sup> As noted, charges for prescribed offences are currently excluded from the jurisdiction of the Youth Justice Division of the Magistrates Court. We note that, before establishing the Youth Justice Division of the Magistrates Court in 1997, Tasmania had a separate Children’s Court.<sup>657</sup>

We consider that a specialist Children’s Court in Tasmania would significantly benefit children and young people. While separate court facilities for children and young people are ideal, we acknowledge that these may be impractical in Tasmania given its population size. In Section 5.5.6, we recommend establishing a new specialist division of the Magistrates Court to deal with child protection matters and criminal charges against children and young people.

### 5.5.5 Youth justice reforms

Strategy 3 of the Draft Youth Justice Blueprint is to ‘establish a therapeutically based criminal justice response for children and young people’ that ‘provides a range of interventions and support options that address criminogenic needs, target the driving factors behind offending behaviours and build upon strengths’.<sup>658</sup> This includes ‘[e]nsuring the availability of graduated sentencing options’ to reduce the number of children and young people re-entering the criminal justice system.<sup>659</sup>

Action 4 of the Draft First Action Plan is to ‘[i]mplement a range of diversion, bail support and community based sentencing programs’.<sup>660</sup> In his February 2023 update, Secretary Bullard advised that work had begun on:

- researching community-based sentencing programs in other jurisdictions
- implementing a pilot program within Community Youth Justice ‘to trial an intensive care team support program with a small number of children and young people who are engaged with the youth justice system and have complex needs’.<sup>661</sup>

### 5.5.6 Our recommendations

The Government's proposed review of the Youth Justice Act offers an opportunity to reconsider the suite of sentencing options available for children and young people and to clarify the sentencing hierarchy. As well as the updated youth justice principles recommended in Section 5.2 (Recommendation 12.12), the new Youth Justice Act should include sentencing principles that identify rehabilitation as the primary purpose of sentencing. In determining an appropriate sentence for a child or young person, courts should be required to consider factors related to a child or young person's trauma background and their child protection and out of home care history.

In developing new community-based sentencing orders, the Government should ensure children and young people on such orders have access to appropriate rehabilitation programs and are supported to comply with the conditions of their orders.

To increase court specialisation for children and young people, we recommend establishing a new specialist division of the Magistrates Court to hear and determine child protection matters (currently heard by the Children's Division) and criminal matters against children and young people (currently heard by the Youth Justice Division). This new division should be constituted by at least three dedicated, full-time specialist magistrates—one based in Hobart, one in Launceston and one in Devonport and Burnie—drawn from the existing pool of magistrates. The specialist magistrates should have an understanding of child and adolescent development, trauma, child and adolescent mental health, children's cognitive and communication deficits, and Aboriginal cultural safety.

The Government should support the Magistrates Court to arrange for the new specialist children's division to be independently evaluated after three years to examine the adequacy of its resourcing.

The Government should also ensure any future redevelopments of Tasmanian court facilities consider modifications to make those facilities less formal and intimidating, and more child-friendly.

Finally, we recommend that the Government funds professional development for judicial officers in adult jurisdictions hearing criminal charges against children and young people.

#### **Recommendation 12.15**

The Tasmanian Government should:

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

- i. rehabilitation is the primary purpose of sentencing a child
  - ii. the list of sentencing options is a hierarchy and a sentencer can only impose a sentence at a particular level of the hierarchy if satisfied that it is not appropriate to impose a sentence that is 'lower' in the hierarchy
  - iii. a sentence imposed on a child should be the minimum intervention required in the circumstances
  - iv. a custodial sentence must only be imposed as a last resort and for the minimum period necessary
  - v. in sentencing a child the court must consider the child's experience of trauma, any child protection involvement or experience of out of home care, disruptions to the child's living situation or education, any mental illness, neurological difficulties or developmental issues experienced by the child, and the child's chronological age and developmental age at the time of sentencing
  - vi. in sentencing an Aboriginal child, the court must consider additional factors including the consequences of intergenerational trauma, historical discriminatory policies, general and systemic racism, and any previous culturally inappropriate responses that may have worsened the effects of trauma on the child
  - vii. there is a presumption against imposing restrictive conditions (such as curfews and non-association conditions) with community-based sentencing orders, which may increase a child's likelihood of breaching a sentencing order and being sentenced to detention
- b. ensure children who are sentenced to a supervised community-based order receive adequate support to comply with the conditions of the order from therapeutically trained, culturally competent staff
  - c. assist and support the Magistrates Court to establish a new division of the Court to hear and determine both child protection matters and criminal charges against children and young people, which should be constituted by at least three dedicated full-time magistrates with specialist knowledge and skills relating to children and young people
  - d. support the Magistrates Court to arrange for the implementation and operation of the Court's new specialist division to be independently evaluated after three years

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

## 6 Creating a child-focused youth detention system

As discussed in Section 4.1, youth detention environments that deprive children and young people of their liberty, dislocate them from family and community, and impose strict rules, discipline and punishment expose children and young people to ‘a unique set of factors that may heighten their risk of being sexually abused’.<sup>662</sup>

The case studies in this volume reveal the cruel, inhumane and degrading environment and culture at Ashley Youth Detention Centre, where some children and young people were subjected to human rights violations, violence, abuse and neglect, including child sexual abuse. In Section 3, we discuss measures to acknowledge this abuse. Here, we focus on measures to protect against such abuse occurring in the future.

In Section 4.2, we note stakeholder views that Ashley Youth Detention Centre resembles an adult correctional facility rather than a youth justice facility focused on rehabilitating children and young people. Former Commissioner for Children and Young People Mark Morrissey told us of a commonly held view among Centre staff that ‘their role was to be custodians first and foremost, akin to prison officers’, with rehabilitation ‘very much a lower order priority’.<sup>663</sup>

We also heard evidence from multiple experts across the areas of law, psychology, social work and criminology that children and young people in detention have complex needs arising from cognitive disability, exposure to family violence, neglect, abuse, trauma, mental illness, substance misuse issues, homelessness, involvement in the child protection system, disrupted education and significant socioeconomic disadvantage.<sup>664</sup>

A detention environment that responds to such needs with punishment, bullying and intimidation—through isolation, force, restraints and unnecessary searches—rather than with trauma-informed, therapeutic care risks further traumatising and marginalising already vulnerable children and young people. It also significantly increases their risk of experiencing child sexual abuse in detention.<sup>665</sup> Such an approach is also ineffective in reducing offending and enhancing community safety.<sup>666</sup>

As noted in Section 5, to minimise the risk of child sexual abuse in detention, every effort must be made to divert children and young people from remand and custodial sentences.<sup>667</sup> However, where a child or young person cannot be, or is not, diverted from remand or a custodial sentence, it is essential that they receive the support and care they need while in detention to turn their life around and avoid returning to detention. This is necessary to protect children and young people against the continuing risk of child sexual abuse in detention, to reduce the risk that they will eventually enter adult prison and to increase community safety by reducing the likelihood of recidivism.<sup>668</sup>

The United Nations Convention on the Rights of the Child states that:

Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.<sup>669</sup>

In this section, we consider the reforms required in Tasmania to achieve a fundamental shift from a punitive, correctional approach to youth detention to an effective, humane, child-focused system that recognises that children and young people are developmentally different from adults and have the unique potential for rehabilitation, given the right support. The Draft Youth Justice Blueprint describes this as a ‘therapeutic approach’ that ‘frames children and young people as vulnerable and in need of support and healing, as opposed to punishment or fear’.<sup>670</sup>

The Northern Territory Royal Commission examined international best practice for youth detention facilities and identified the following key features of effective systems, where violent incidents were rare and recidivism rates were low:

- small, ‘normalised’ facilities that reflect a residential design<sup>671</sup>
- intensive therapeutic services that address the immediate causes of a young person’s offending and the problems in a young person’s life, such as drug and alcohol misuse and homelessness, that make offending more likely<sup>672</sup>
- high-quality education (including vocational training) as a central part of the facility’s operations<sup>673</sup>
- structured, full days and a wide range of activities to keep children and young people busy<sup>674</sup>
- highly skilled staff who actively engage with children and young people, model positive behaviours and can manage difficult behaviours<sup>675</sup>
- security that is achieved primarily through relationships between children and young people and staff, rather than through ‘the use of fences, locks, isolation and restraints’<sup>676</sup>
- community involvement in the day-to-day operation of the facility<sup>677</sup>



- strong leadership from senior managers who are ‘committed to the vision of reform’<sup>678</sup>
- evidence-based decision making in youth justice reform, noting that ‘the evidence often points the opposite way to what many people intuitively assume is the best approach’.<sup>679</sup>

As outlined in Section 2, the Tasmanian Government has announced a substantial youth justice reform agenda, encapsulated in its Draft Youth Justice Blueprint, Draft First Action Plan and Keeping Kids Safe Plan.<sup>680</sup> This reform agenda follows several earlier reviews and unsuccessful attempts at youth justice system reform (outlined in Chapter 10), including attempts to implement a therapeutic model of care in youth detention in 2017 and 2018 via the ‘Ashley Model’ and the ‘Ashley+ Model’ (also referred to as the ‘Ashley+ Approach’).<sup>681</sup>

Given that we did not undertake a full inquiry into the youth detention system, we do not make detailed recommendations on all aspects of youth detention. Instead, we focus primarily on the issues that stood out in the evidence we received as the most relevant to preventing child sexual abuse while a child or young person is in detention. Our recommendations in this section address:

- the design of the detention facility intended to replace Ashley Youth Detention Centre
- measures to increase safety for children and young people in detention through the use of closed-circuit television cameras, body-worn cameras and viewing panel swipe readers
- the need for highly skilled staff who can apply a trauma-informed and therapeutic model of care
- implementing a multidisciplinary approach to meeting the needs of children and young people in detention
- access to health care for children and young people in detention
- children and young people’s access to high-quality education in detention
- promoting connections between children and young people in detention and their families and communities
- effective exit planning and support for children and young people after their release from detention
- the process for transferring children and young people from youth detention to adult prison facilities.

Our recommendations to ensure youth detention in Tasmania is culturally safe for Aboriginal children and young people are in Section 7.3. We discuss leadership in the youth detention system in Section 4.4.

## 6.1 Designing a contemporary, best practice detention facility

As outlined in Section 2, the Government has announced that it intends to replace Ashley Youth Detention Centre with several new facilities, including one ‘detention/remand centre’ in southern Tasmania.<sup>682</sup> According to the Government’s Draft First Action Plan, this facility will be ‘purpose-built’ and will ‘provide the opportunity for intensive intervention and rehabilitation through a therapeutic model of care’.<sup>683</sup>

We note that international human rights instruments require children and young people on remand to be separated from children and young people who have been convicted and sentenced.<sup>684</sup> We acknowledge that if the total package of our recommendations was implemented as intended, there would be a very small group of older children whose danger to the community could not be managed in community settings, who would be remanded in custody. Although it is undesirable for children on remand to be detained with children who have been sentenced, we recognise that the small numbers involved may make separating these groups impractical and could effectively result in isolation.

### 6.1.1 Physical design

According to the United Nations Committee on the Rights of the Child, children deprived of liberty should be ‘provided with a physical environment and accommodation conducive to the reintegrative aims of residential placement’.<sup>685</sup> As noted, the most effective youth detention facilities are those that have ‘moved away from the institutional prison model ... towards more normalised, home like facilities’.<sup>686</sup> This is in part because physical design affects behaviour. In a facility based on a residential design, young people and staff perceive themselves and others more positively than in an institutional design, and as a result, the atmosphere is calmer, stress is reduced and behaviour improves.<sup>687</sup>

Elena Campbell, Associate Director, Research, Advocacy and Policy at the Centre for Innovative Justice, referred positively to the approach of the Diagrama Foundation in Spain, which runs 35 centres for children and young people remanded or sentenced to custody.<sup>688</sup> According to a report prepared by the Diagrama Foundation for the Northern Territory Royal Commission:

As far as possible we make our centres feel like a normal environment with young people engaged in their decoration, upkeep, gardening; with everyday furniture rather than ‘prison’ furniture and a daily rhythm that is appropriate to the age of the young person – a normal 9:30 or 10:00pm bedtime. This provides young

people with greater opportunities to learn and they go to bed tired and sleep better. We also have fewer problems caused by the frustration of boredom or loneliness. All of the above contributes to making our centres feel like safe, normal environments where disruptions and use of force are low. Young people can focus on their progression and build skills for successful life in the community.<sup>689</sup>

While the Diagrama Foundation report refers to six months as being the ‘minimum time recommended’ in its centres, it notes that ‘even for young people who are with us for short periods, however, we expect some degree of progression towards developing positive behaviours’.<sup>690</sup> Its approach is therefore not inconsistent with an approach that also seeks to ensure detention is for as short a time as possible.

Anthony McGinness, former Noetic Solutions consultant, cited the example of the ‘Missouri Model’, which has been adopted in several United States jurisdictions and has recidivism rates as low as 15 per cent.<sup>691</sup> This model uses small, homelike secure facilities that are ‘designed to look like schools rather than prisons’ and incorporate pets and live plants.<sup>692</sup>

In recommending new secure facilities for Darwin and Alice Springs, the Northern Territory Royal Commission concluded that:

Each facility should be designed on a campus model that has facilities for the accommodation, education, training and basic service delivery for the detained population within a secure perimeter. The facilities should be built and finished to a standard that would be considered acceptable in a new fee-for-service boarding school.<sup>693</sup>

The Victorian Commission for Children and Young People has also emphasised the importance of secure youth justice facilities closely resembling a home, where children and young people have ready access to communal spaces, including a kitchen, lounge area and outdoor spaces, and where soft furnishings, artwork, books and games contribute to a homelike environment.<sup>694</sup> We agree with these approaches.

Also, the physical design of the new facility should address the needs of girls and young women, gender diverse children and young people, and children and young people with disability. We discuss the needs of Aboriginal children and young people in detention in Section 7.

The new facility should also incorporate features that keep children and young people safe from sexual abuse. The National Royal Commission recognised that building and design features, such as the location of closed-circuit television cameras, could improve the observation of children’s interactions with each other, as well as interactions with staff.<sup>695</sup> An expert in harmful sexual behaviours told us that there are design strategies available in various institutions to reduce the opportunity for harmful sexual behaviours—for example, positioning toilets in a central area where everyone can see who is entering and exiting, and locating staff near high-risk areas such as bathrooms or bedrooms.<sup>696</sup>

We discuss harmful sexual behaviours in detention in Section 8. We discuss closed-circuit television cameras and related issues in Section 6.2.

### 6.1.2 Size

The best-performing youth detention facilities tend to be small.<sup>697</sup> The largest secure facility in Missouri has 36 beds, while the Diagrama Foundation's centres range from small 12-bed facilities to larger facilities for around 70 young people.<sup>698</sup> The Northern Territory Royal Commission rejected any suggestion that a large facility be built 'for the sake of having spare capacity in case of an unexpected increase in the number of young people committed to detention'.<sup>699</sup> It recommended a total capacity of 46 beds across two proposed facilities (in Darwin and Alice Springs), with 'an additional 13 beds available to accommodate for higher than average days'.<sup>700</sup> It also recommended that each facility have small accommodation units with four to six bedrooms each.<sup>701</sup>

As noted in Section 5.4, on an average day in 2021–22, there were eight children and young people aged 10 to 17 years in detention in Tasmania.<sup>702</sup> Ashley Youth Detention Centre has 40 beds.<sup>703</sup> This is too large. Even with the more recent increase in remand numbers (outlined in Section 5.4), Tasmania's small youth detention population lends itself to establishing a smaller secure facility.

In Section 5.1, we recommend that the Government increases the minimum age of criminal responsibility to 14 years and works towards increasing the minimum age of detention (including remand) to 16 years (Recommendation 12.11). In that section, we also recommend adopting diversionary and sentencing processes to reduce the number of children and young people entering detention. The combined effect of these measures would be that, even in the short term, only young people aged 14 to 17 years would be eligible for remand or a custodial sentence, and the detention population would be smaller than at present.

As outlined in Section 5.1.2, the Tasmanian Government has committed to increasing the minimum age of detention to 14 years, although it will not do this until 'new bail and sentencing options [are] developed to better support children and young people under the age of 14'.<sup>704</sup> This is likely to take time because it appears to be intended to form part of the Government's proposed review of the Youth Justice Act.<sup>705</sup> Until such changes are implemented, children as young as 10 could continue to be remanded or sentenced to detention. Nevertheless, this does not alter our view that any new detention facility should be small.

### 6.1.3 Location

In March 2023, the Government announced that two sites had been shortlisted for the new detention facility, identified due to their:

... substantial size, separation from major residential areas, their proximity to Hobart, the limited visibility (or with capacity for screening) from surrounding properties and their appropriate zoning under the relevant planning scheme.<sup>706</sup>

At the time of writing, a site for the new detention facility had not been selected. We note that one of the shortlisted sites is in Risdon. The Northern Territory Royal Commission said that new secure youth detention facilities should not be located on, or close to, adult prison precincts.<sup>707</sup> We agree. Locating youth detention facilities near adult prisons risks undermining the distinctive approach of effective youth detention systems, which focus on rehabilitation and recognise that children and young people have unique needs based on their age and stage of development.

We note that locating a new detention facility in or near Hobart will have the effect of dislocating some children and young people from their communities and families. As discussed in Chapter 10, in 2016, Noetic Solutions recommended establishing two new purpose-built detention facilities to replace Ashley Youth Detention Centre to keep detained children and young people closer to their families and communities.<sup>708</sup>

However, we also note that the small Tasmanian youth detention population may not justify multiple detention facilities and that locating a single new facility in Hobart has the advantage of providing improved access to services and being more likely to attract a larger pool of professional staff than a regional location.<sup>709</sup> In Section 6.7, we discuss the need to support families to visit children and young people in detention.

#### **Recommendation 12.16**

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

This includes features that:

- a. promote the development of trusting and therapeutic relationships between staff and children and young people
- b. facilitate and enhance trauma-informed, therapeutic interventions for children and young people
- c. minimise stigma to children and young people

- d. facilitate and promote connections between children and young people, and their families and communities
- e. protect children and young people against the risks of child sexual abuse (including harmful sexual behaviours)—for example, by enabling line-of-sight supervision as far as possible, without infringing on children and young people’s privacy.

## 6.2 Security measures to increase children’s safety in detention

If therapeutic interventions are to be effective, children and young people in detention must feel safe. As noted, in best practice youth detention facilities, security—and therefore feelings of safety—are achieved primarily through positive relationships between staff and young people and through constant, active supervision by staff, rather than through security features such as surveillance that are common in adult prisons (refer to the discussion in Section 6.3.1). However, establishing such an approach in Tasmania is likely to take time, particularly in a system that has previously adopted a highly punitive approach to youth detention.

Surveillance cameras in youth detention facilities enable internal and external oversight of interactions in the facility, improve staff accountability and help to prevent potential abuses of power.<sup>710</sup> According to the Northern Territory Royal Commission, ‘[t]he availability of video evidence of use of force incidents provides the best objective evidence of what has occurred’.<sup>711</sup> It recommended that:

- closed-circuit television cameras cover all parts of youth detention centres other than bathroom facilities<sup>712</sup>
- all closed-circuit television camera footage be retained for at least 12 months<sup>713</sup>
- body-worn video cameras that record both video and sound be introduced in youth detention centres.<sup>714</sup>

As described in Chapter 11, Case study 1, several victim-survivors who had been detained in Ashley Youth Detention Centre told us they had been sexually abused in parts of the Centre where there were no surveillance cameras; they advocated strongly for extra cameras to keep children and young people safe. Some victim-survivors also told us that staff had watched them while they were showering through ‘viewing panels’ designed to enable observation of a child or young person at risk of suicide or self-harm.<sup>715</sup>

The Government's Keeping Kids Safe Plan commits it to making the following improvements to security and safety at Ashley Youth Detention Centre:

- updating closed-circuit television coverage and installing more cameras to cover blackspots<sup>716</sup>
- installing a closed-circuit television control room with trained personnel to monitor coverage<sup>717</sup>
- developing and implementing a security risk management plan with supporting policies and procedures<sup>718</sup>
- investigating the use of body-worn cameras and 'viewing panel swipe readers', requiring an access control card to be read on a reader before the viewing panel can be opened<sup>719</sup>
- moving from paper records to an electronic records management system.<sup>720</sup>

Most of these actions were due to be completed by December 2022. Recommendations from the investigation into body-worn cameras were due to be implemented by July 2023.<sup>721</sup> In February 2023, Secretary Bullard advised us that the security risk management plan had been completed and that all other actions were 'underway'.<sup>722</sup>

In June 2023, the Department told us that although it has explored installing closed-circuit television across Ashley Youth Detention Centre, it has been advised that it is not possible to implement coverage across the entire current site.<sup>723</sup> The Department said it is investigating other forms of video and audio surveillance and that '[a]ppropriate surveillance will be a key consideration in the design of the new youth detention facilities'.<sup>724</sup> It is not clear to us why it is not possible to implement closed-circuit television coverage across the entire current site, nor what other forms of video and audio surveillance the Department may be exploring.

While we are encouraged by the Department's commitments and activities in relation to security at Ashley Youth Detention Centre and the proposed detention facility, we are concerned that there are still parts of Ashley Youth Detention Centre that are not covered by surveillance cameras. The Department must ensure all public areas of the Centre are subject to effective electronic surveillance. This should not include children's rooms, bathrooms or other parts of the Centre where children's privacy may be infringed, such as spaces where children may be viewed undergoing a partially clothed search (although surveillance should cover staff who conduct the search).

We support introducing viewing panel swipe readers at Ashley Youth Detention Centre. We also support the introduction of body-worn cameras at the Centre to supplement closed-circuit television cameras because body-worn cameras have the advantage of recording sound, which we consider will provide more information on incidents, improve staff accountability and strengthen oversight of youth detention.



In recommending these security features, we are persuaded by the voices of victim-survivors who told us that more cameras were needed to keep children and young people in detention safe. However, we do not consider that such security features should be necessary indefinitely. We are mindful of the fact that a strong focus on surveillance is not consistent with the best practice approach of achieving security in youth detention facilities primarily through constructive relationships between staff and children and young people.

Therefore, we recommend that the continuing use of surveillance cameras in youth detention be the subject of regular annual reviews by the new Commission for Children and Young People (recommended in Chapter 18, Recommendation 18.6). These investigations should seek the views of children and young people in detention about whether surveillance cameras make them feel safe, and whether such mechanisms should be used in the proposed new detention facility intended to replace Ashley Youth Detention Centre.

Footage from surveillance cameras needs to be properly managed to support effective oversight. We note that the Keeping Kids Safe Plan does not address the issue of management or retention of closed-circuit television camera footage.

The Ashley Youth Detention Centre procedure on 'CCTV Surveillance Cameras' states that the primary function of surveillance cameras is 'to provide recorded footage that may be viewed in the event of an incident or allegation' and that '[f]ootage will be reviewed, recorded and stored securely by the [Fire, Safety and Security Coordinator] on a regular basis'.<sup>725</sup> The procedure also indicates that footage of incidents required for investigation will be 'downloaded to disc' and 'retained footage will be transferred to portable hard drive on a regular basis'.<sup>726</sup> These requirements should be clarified and strengthened.

The National Royal Commission recommended that institutions that engage in child-related work implement a series of principles for record keeping, including creating and keeping full and accurate records of all incidents affecting child safety and wellbeing, and maintaining those records appropriately.<sup>727</sup> The National Royal Commission also recommended that public records authorities guide institutions on identifying records that may become relevant to an actual or alleged incident of child sexual abuse and on retaining and disposing of such records (Recommendation 8.3).<sup>728</sup>

In 2019, in response to Recommendation 8.3, the Tasmanian Office of the State Archivist issued a notice of a 'disposal freeze' on records relating to children.<sup>729</sup> The stated basis for the freeze was 'the complexity of identifying records that may be relevant for future disclosures of child abuse', noting that some children and young people take time to disclose abuse, and the State should ensure all relevant records are retained.<sup>730</sup>

The disposal freeze requires all organisations and agencies providing services to children to ‘keep all records that contain the best information about children, services provided to them, and employees that provide the service, until 2029’.<sup>731</sup> We consider that this would include footage from surveillance cameras and body-worn cameras in youth detention. The Office of the State Archivist will review the disposal freeze before the National Redress Scheme ends.<sup>732</sup>

## **Recommendation 12.17**

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

## 6.3 Highly skilled staff applying a therapeutic model of care

### 6.3.1 Best practice

As noted, the best-performing youth detention facilities have highly skilled staff who actively engage with children and young people, model positive behaviour and can manage difficult behaviours through trauma-informed responses and de-escalation techniques.

At secure centres run by the Diagrama Foundation, highly qualified specialist staff known as ‘social educators’ work to ‘build warm, parenting relationships’ with young people by acting as encouraging and supportive role models, while setting ‘consistent, clear and fair boundaries to help young people understand the positive and negative consequences of their behaviour’.<sup>733</sup> This reflects a model of care that is ‘centred around the themes of relationships and emotions, cognition, behaviour and progression’.<sup>734</sup>

‘Progression’ in this context refers to a system of rewards and privileges used in Diagrama facilities that ‘encourages young people to progress through a five-staged model from induction through to autonomy’.<sup>735</sup> Rewards include opportunities to work, study and socialise in the community. Young people can lose these privileges and then have to re-earn them.<sup>736</sup>

The Diagrama Foundation states that social educators ‘genuinely care about the young people they work with’ and support them throughout every aspect of their day.<sup>737</sup> Each Diagrama centre has separate security staff who ‘act as a last resort in incident management’ and ‘stay in the background’ as far as possible—they are not involved in the day-to-day care of children and young people.<sup>738</sup>

According to the Diagrama Foundation, its secure centres are:

... stable and orderly places where young people feel safe and there are very low levels of disruptions. Therefore use of restraint and force are uncommon in our centres: in 2018, only 9.51% of young people across our centres were restrained and only 6.85% committed a serious incident [including verbal abuse and threatening behaviour] beyond their first two months in custody.<sup>739</sup>

In the Missouri Model, staff in detention facilities are known as ‘youth specialists’, who are responsible for the ‘safety, personal conduct, care and therapy’ of children and young people.<sup>740</sup> Staff undergo an intensive recruitment process to determine whether they are committed to helping children and young people succeed and have the necessary attributes for the role, such as good listening skills, empathy and an ability to create respect.<sup>741</sup> Youth specialists must complete 236 hours of training in their first two years, including multiple sessions on youth development, family systems and group facilitation.<sup>742</sup>

Youth specialists engage in constant, active, ‘eyes-on, ears-on’ supervision of children and young people—talking to them, engaging in activities with them and noticing any changes in their facial expressions and body language or in group dynamics that may indicate that intervention is required.<sup>743</sup> Youth specialists are also extensively trained in conflict management and techniques ‘designed to defuse potential trouble and foster a safe environment’.<sup>744</sup>

We discuss the recruitment of a highly skilled workforce for Tasmanian youth detention facilities in Section 4.7.

### 6.3.2 Our evidence

In contrast with the approaches outlined in Section 6.3.1, the case studies in Chapter 11 describe the culture that existed at Ashley Youth Detention Centre, where we heard that some staff used threats of physical violence against children and young people, subjected them to unnecessary strip searches and sometimes placed them in forms of isolation, often as punishment and sometimes using force or restraints (refer also to Sections 4.2 and 9). As noted in Chapter 11, Case study 1, such practices may have further traumatised and criminalised children and young people.

In Chapter 10 and Chapter 11, Case study 3, we also describe the ways in which the Behaviour Development System—an incentive-based behaviour management protocol that allocated ‘benefits’ or ‘restrictions’ to a young person based on a colour ranking—and in particular the ‘Blue Program’, were used to punish and isolate children and young people. The Blue Program created another ranking that was lowest on the behaviour management spectrum and reserved for the children and young people displaying the most challenging behaviours. It took various forms over many years, but, in 2019, it was described as involving a young person being ‘fully segregated from Ashley School, daily programs and activities, other young people in their Unit (subject to risk assessment) and the normal routine of the Centre’.<sup>745</sup>

Restrictions on the ‘red’ level in the Behaviour Development System included a bedtime of 7.30 pm (compared with a bedtime of 10.00 pm for a young person on the ‘green’ level), with young people confined to their rooms until breakfast at 8.00 am the following day.<sup>746</sup>

As discussed in Section 4.2.2, we heard concerns from staff that some children and young people were singled out by staff for unfavourable treatment through the Behaviour Development System because they were disliked.<sup>747</sup>

Also, as described in Section 4.2.2, we heard that some operational staff at Ashley Youth Detention Centre saw themselves as being akin to prison guards. Professor White told us that, in his view, formed while taking part in an investigation into the death of a young person at Ashley Youth Detention Centre in 2010, the operational staff were:

... basically “lockup people”. Their role is essentially a prison guard role, and that role is reflected in both their approach and their training ... It is not tied directly to the rehabilitation or restoration ideals which are commonly associated with youth justice.<sup>748</sup>

Our case studies illustrate that this observation is still relevant to more recent practices. Former Ashley Youth Detention Centre staff member Alysha (a pseudonym) indicated she did not observe in ‘any way, shape or form’ a culture at the Centre that valued rehabilitation and restorative practices.<sup>749</sup> We also heard that operational staff have historically not been required to hold appropriate qualifications.<sup>750</sup> We discuss the practices, qualifications, training, recruitment and impact of operational staff in Section 4.7.

### 6.3.3 Practice improvements

The *Ashley Youth Detention Centre Practice Framework* (‘Practice Framework’)—developed in 2020, with implementation starting in 2021—describes itself as a ‘therapeutic, evidence-based framework’ to guide how staff ‘work in a therapeutic way with young people in detention’.<sup>751</sup> It includes a section on ‘therapeutic and trauma-informed practice’, which refers to the importance of staff working in ways that acknowledge children and young people’s experiences of trauma, recognise their responses and provide opportunities to learn new responses and behaviours.<sup>752</sup>

The Practice Framework has six practice principles that emphasise building healthy and positive relationships, creating an environment where young people and staff feel safe and secure, providing opportunities for young people to connect with their families and communities, and giving young people a voice in decisions that affect them.<sup>753</sup> The Practice Framework is supported by the Centre’s Learning and Development Framework, which specifies mandatory professional development requirements for staff.<sup>754</sup>

Pamela Honan, Director of Strategic Youth Services, said that implementation of the Practice Framework was in its ‘early stages’ and acknowledged that, without the appropriate skill set to work with children and young people demonstrating challenging behaviours, staff may fall back on punitive practices.<sup>755</sup> The Government has contracted the Australian Childhood Foundation to review the Practice Framework and the Learning and Development Framework.<sup>756</sup>

In 2021, Ashley Youth Detention Centre revised the Behaviour Development System and renamed it the Behaviour Development Program.<sup>757</sup> According to Ms Honan, the revised program was piloted and a new procedure for its use finalised in June 2022.<sup>758</sup> Secretary Pervan told us that the new Behaviour Development Program was ‘a more positively focused and less punitive system’.<sup>759</sup>

The Government has also:

- contracted the Australian Childhood Foundation to deliver training for the Certificate IV in Youth Justice for staff at Ashley Youth Detention Centre who do not already have qualifications in youth work (refer to Section 4.7.1)<sup>760</sup>
- engaged an external provider to deliver training for all staff at Ashley Youth Detention Centre in ‘positive behaviour support’, ‘positive approaches to behaviour and safer de-escalation’ and ‘physical intervention’ by June 2023.<sup>761</sup>

In addition, the Government has committed to developing and implementing standard operating procedures for security, including a review of existing procedures for using handcuffs.<sup>762</sup> The Department has also updated its procedure on personal searches of children and young people in detention in light of legislative changes to the requirements for searches in December 2022—these issues are discussed in Section 9.1.

More broadly, the Government has committed to developing a ‘Youth Justice Model of Care’ by 2025 to outline its approach to caring for children and young people across the youth justice system (not just in detention) and to establish an operating philosophy, service objectives and service standards based on therapeutic, trauma-informed care.<sup>763</sup>

#### **6.3.4 Our recommendations**

As noted, Tasmania’s youth detention system needs to undergo a fundamental shift from a punitive approach to one that is centred on rehabilitation. Staff are central to this change. Operational staff must be equipped with the skills needed to undertake trauma-informed, culturally safe, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond to challenging behaviours without resorting to force.

The Government’s practice improvements described in Section 6.3.3 are positive, but more needs to be done. In Section 4.7.3, we recommend several changes to ensure staff at Ashley Youth Detention Centre and any new detention facility are appropriately trained and qualified, and have the right skills and attitudes to work positively and effectively with children and young people in detention.

Also, in Section 7.3.5, we recommend that staff be equipped with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including through trauma-informed and culturally safe responses to children and young people engaging in self-harm or other challenging behaviours.

To support these recommendations, we consider that the Youth Justice Model of Care should include a specific custodial operating philosophy that is centred on rehabilitation and non-punitive, child-focused, therapeutic practice, and that recognises that this is the most effective strategy to support children and young people to make lasting behavioural changes, and thereby ensure community safety.

The Youth Justice Model of Care should also directly address the use of force, restraints and isolation in detention to ensure these tools are used minimally and only where other strategies in response to challenging behaviours have not worked. These tools should never be used as a punishment. This is discussed in Section 9.

Further consideration is needed on behaviour management programs in youth detention. As outlined in Section 6.3.2, the Behaviour Development System was used in a punitive way and does not appear to have been effective in promoting positive behaviour. We are not convinced that its replacement, the Behaviour Development Program, is different enough to warrant its continued use in Ashley Youth Detention Centre, or its use in any future youth detention facility.

However, we are also aware that carefully designed behaviour management systems based on incentives and rewards are in use in youth justice systems in jurisdictions with best practice detention facilities, such as those run by the Diagrama Foundation. We also note that the Northern Territory Royal Commission recommended that a ‘continuum of behaviour management tools’ be developed for youth detention ‘to ensure that staff have a range of measures available to them to respond to inappropriate behaviour by young people without the use of force’, including an incentive system designed to encourage responsible behaviours.<sup>764</sup> It indicated that behaviour management tools should be simple, fair and clear to staff and to children and young people, and that any incentive system should not restrict a young person’s access to rehabilitation programs, education or physical exercise.<sup>765</sup>

We note that the *Inspection Standards for Youth Custodial Centres in Tasmania* include standards for behaviour management programs.<sup>766</sup> We recommend that these standards be reviewed in light of international best practice and research on age-appropriate responses to children and young people with trauma backgrounds and emotional regulation challenges.

## **Recommendation 12.18**

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



- c. staff in youth detention facilities have the skills needed to undertake evidence-based, trauma-informed, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to force or restrictive practices
  - d. implementation of the Youth Justice Model of Care and updated Practice Framework for youth detention is monitored by the governance structure outlined in Recommendation 12.7.
2. The Custodial Inspector, or the body responsible for inspection standards for youth detention centres in Tasmania, should review standards and guidelines on the appropriate use in youth detention of behaviour management programs that incorporate incentives and rewards, having regard to international best practice and research on effective responses to children and young people with trauma backgrounds and emotional regulation challenges.

## 6.4 A collaborative, multidisciplinary approach to meeting children's needs

As noted, we heard that most children and young people in detention have highly complex needs arising from cognitive impairment, exposure to neglect or abuse, trauma and mental illness. Most also have drug and alcohol misuse issues.<sup>767</sup> Many have a history of involvement with the child protection system.<sup>768</sup> As discussed in Section 7, Aboriginal children and young people are over-represented in youth detention because of the impacts of colonisation and intergenerational trauma, and have distinct cultural needs.

We also heard that, over the past decade, the needs of children and young people in the youth justice system in Tasmania and elsewhere have become greater and more complex, and their offending has become more serious.<sup>769</sup> Professor James Ogloff AM, University Distinguished Professor of Forensic Behavioural Science, told us that youth justice systems across Australia have not kept pace with this changing cohort.<sup>770</sup>

An effective youth detention system must address the complex needs of children and young people, as well as the factors contributing to their offending behaviour.<sup>771</sup> This requires comprehensive assessments on admission, child-centred case planning and case management, and delivery of individualised therapeutic services that address health, wellbeing and criminogenic needs, including interventions to address offending behaviour. Such work requires a multidisciplinary approach.

Adjunct Associate Professor Mitchell told us that it is essential to look at 'the whole child' and adopt a common language and approach across all professionals (or disciplines) working with children in detention:

If we ... brought all of the key stakeholders (justice, disability, mental health, education and so on) together to support these kids in a way that is coordinated and collaborative, we will get better outcomes than if we try to work separately. These young people have complex needs across every domain of their life and it's going to require a concerted, comprehensive and sustained approach to guide them through the next chapter of their life if we want to change the trajectory from them ending up in adult prison.<sup>772</sup>

In Spain, each Diagrama secure facility has a 'technical team'—comprising teachers, psychologists and social workers—which is responsible for developing and delivering an individualised plan for each child or young person.<sup>773</sup> These plans are tailored to the child or young person's offending behaviour and include interventions that are a mix of one-on-one counselling, 'follow-up after an emotional outburst' and group work.<sup>774</sup>

#### **6.4.1 Multidisciplinary approaches and case management at Ashley Youth Detention Centre**

Secretary Pervan told us that Ashley Youth Detention Centre 'operates as a multi-disciplinary centre' and that operational and other staff 'work collaboratively through multidisciplinary teams, weekly review meetings, and program meetings'.<sup>775</sup>

We heard about professionals, teams and policies that might have been able to support a multidisciplinary approach and case management at Ashley Youth Detention Centre, including:

- the 'Professional Services Team', whose role was to provide 'therapeutic supports and services to young people in detention', including developing case and care plans, arranging restorative case conferencing, making referrals to other services and advising operational staff on behaviour management strategies<sup>776</sup>
- a Case Management Officer or Case Manager who was part of the Professional Services Team<sup>777</sup>
- the 'Multi-Disciplinary Team', whose role was to provide 'clinical assessment, review, case planning and referral of the complex needs of young people in custody'<sup>778</sup>
- the 'Centre Support Team' (or, since 2022, the 'Weekly Review Meetings'), which met weekly to assess children and young people against the Behaviour Development Program, consider incidents at the Centre, make placement decisions and consider requests from young people<sup>779</sup>
- Case Management Guidelines, dated 2014, which outline that each child or young person must undergo, among other things, a 'Case Management Assessment' within two working days of admission, to be completed by the 'Case Manager'.<sup>780</sup>

It was not clear to us how these different roles, teams and policies operated in practice to achieve a multidisciplinary approach to meeting the needs of children and young people in detention. The extent to which children and young people experienced a highly skilled, professional, multidisciplinary response as part of their daily routine was also unclear.

We heard that the Multi-Disciplinary Team had previously not worked effectively.<sup>781</sup> Ms Honan told us that, before 2021, meetings of the Multi-Disciplinary Team consisted mostly of operational staff, with limited representation from the Professional Services Team, and that, as a result, ‘operational pressures dominated decision making and appear to have “trumped” the therapeutic needs of young people’.<sup>782</sup> Similarly, Ms Gardiner told us that, during her time at the Centre in 2018, meetings of the Multi-Disciplinary Team ‘rarely made any therapeutic recommendations’.<sup>783</sup>

Ms Honan also referred to tensions between the operational and professional services staff on the Multi-Disciplinary Team:

There was a noticeable lack of professional regard and collaboration between the two streams with little to no external involvement from stakeholders in Multi-Disciplinary Team (MDT) meetings. Because of this dynamic and the dominance of operational staff represented at MDT, the multi-disciplinary process was ineffective. Practices had become punitive resulting in the moving or containment of residents in response to incidents, rather than understanding and responding in a trauma informed way to triggers and escalating behaviours. The two streams were philosophically opposed and silo[ed]. I would describe much of the workforce as disempowered.<sup>784</sup>

Secretary Pervan told us that a Multi-Disciplinary Team meeting must be held in respect of each young person at Ashley Youth Detention Centre every four weeks, at minimum.<sup>785</sup> While this requirement was stated in an earlier version of the Multi-Disciplinary Team’s terms of reference, it does not appear in the current terms of reference.<sup>786</sup> Rather, the current terms of reference only require that a young person be discussed at a Multi-Disciplinary Team meeting on admission ‘if behavioural or concerning behaviours are identified’ and three weeks before their release.<sup>787</sup> The Multi-Disciplinary Team’s terms of reference do not explain what kind of behaviours might give rise to the need for such a discussion. The nature of this multidisciplinary response appears very different from the multidisciplinary approach to working with children and young people in Spain’s Diagrama model (discussed previously).

According to Ms Honan, the Centre Support Team also did not work as effectively as it should have, with ‘therapeutic interventions competing with operational pressures’ and documentation relating to decisions and actions poorly recorded or not recorded at all.<sup>788</sup> Ms Honan acknowledged that the Centre Support Team had previously operated in a punitive manner.<sup>789</sup> Ms Gardiner observed that the Centre Support Team was ‘driven by the agenda’ of operational staff and did not consider or incorporate the views of the Multi-Disciplinary Team.<sup>790</sup>

The Ashley Youth Detention Centre Case Management Guidelines provide for the participation of children and young people in case management processes in the following terms:

Young people are encouraged to participate in all Case Management processes. They should be included in decision-making forums and processes and the development, implementation and review of their Case Plans and casework strategies.<sup>791</sup>

Despite this, it is not clear to us that children and young people were given the opportunity to participate in case management processes at Ashley Youth Detention Centre.

#### 6.4.2 Practice improvements

Ms Honan said that when she began in her role in October 2019, there was a ‘tense divide’ between the Professional Services Team and operational staff, which was ‘exacerbated by the command and control management style of senior managers’.<sup>792</sup> However, at the time of her statement to our Commission of Inquiry in August 2022, she described the relationship between the two teams as ‘respectful, supportive, collaborative and equal’.<sup>793</sup> Ms Honan attributed the changes in the relationship to a range of factors, including implementing the Practice Framework, appointing new senior managers in both teams and ‘the shift to a more accountable and collaborative style of leadership and decision making’.<sup>794</sup>

Ms Honan also told us that, following a review of its terms of reference in 2021, the Multi-Disciplinary Team became more broadly representative and was well attended by staff from the Ashley Youth Detention Centre School, the Department of Health and the then Department of Communities.<sup>795</sup>

In February 2023, the Department advised us that it:

- had contracted the Australian Childhood Foundation to provide ‘clinical review and support services, including specialist clinical services for young people covering emotional regulation, trauma-informed counselling and therapeutic supports’<sup>796</sup>
- was establishing a multidisciplinary Clinical Services Team to deliver ‘therapeutic clinical services for assessment, support and rehabilitation of young people in contact with the youth justice system, with a strong initial focus’ on detention.<sup>797</sup>

These are positive steps, but it is not clear to us how the Clinical Services Team will fit within and work with existing groups at Ashley Youth Detention Centre—particularly the Professional Services Team, the Multi-Disciplinary Team and the Weekly Review Meetings.

### 6.4.3 Services for children and young people on remand

As discussed in Section 5.4, children and young people on remand make up a large proportion of the youth detention population in Tasmania. In that section, we make several recommendations aimed at increasing opportunities for bail and diverting children and young people from remand. We also recommend that the Tasmanian Government works towards increasing the minimum age of detention, including remand, to 16 years. Implementing these recommendations would significantly reduce the number of children and young people on remand in Tasmania.

Nevertheless, following these changes, there may still be a small number of young people who would be denied bail and remanded due to the complexity of their needs and their high risk of offending while on bail. While we acknowledge the practical challenges associated with providing services to children and young people who may only be on remand for a short period, in our view, remand presents an opportunity for therapeutic intervention that should be seized wherever possible. The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (referred to as the ‘Beijing Rules’) require that children and young people on remand:

... receive care, protection and all necessary individual assistance—social, educational, vocational, psychological, medical and physical—that they may require in view of their age, sex and personality.<sup>798</sup>

However, it is also important to note that, while all children and young people who are on remand have been charged with an offence, those whose charges have not yet been determined have not been found guilty of an offence and are therefore entitled to the presumption of innocence. Professor Ogloff referred to the need to ensure children and young people on remand can openly discuss their behaviour with clinicians without incriminating themselves.<sup>799</sup>

The 2017 review of the Victorian youth justice system undertaken by Professor Ogloff and Penny Armytage considered the issue of services for children and young people on remand.<sup>800</sup> The review report noted that, despite introducing education for children and young people on remand in Victoria, there remained ‘a concerning lack of activity and programs’ delivered to remandees, which, combined with the lack of an effective custodial operating model and daily routine, had ‘led to a largely unsettled and tense environment for all young people—on remand and sentenced alike’.<sup>801</sup>

The Victorian review described the reluctance to address offending behaviour while young people were on remand as ‘a missed opportunity to deal early and effectively with criminogenic risk and needs’ and observed that programs could be delivered that address offending behaviours without needing to explicitly address offence types.<sup>802</sup> It recommended that rehabilitation programs and interventions be offered to children and young people on remand, with legislative protections to prohibit using disclosures made during such programs or interventions as evidence of guilt at trial.<sup>803</sup> We agree with this approach.

#### 6.4.4 Our recommendations

An effective youth detention system requires a coordinated, multidisciplinary, child-centred approach to meeting the needs of each child or young person in detention, including—to the extent practicable—those on remand. All children and young people in detention should experience highly skilled, professional, multidisciplinary supports as part of their daily routine. A multidisciplinary approach must bring together all the services necessary to fully support each child or young person and must not allow operational concerns to trump rehabilitation and therapeutic interventions. It must also provide genuine opportunities for each child or young person to participate in the decision making that affects them.

While we are encouraged by the Government’s recent and proposed practice improvements, we are concerned that case management processes are unclear. The large number of teams involved in the care and management of each young person in detention creates scope for confusion and disagreement. A clearer, simpler approach is needed.

We also recommend developing a memorandum of understanding between all key stakeholders across justice, health, education, child protection and disability support services to enshrine a therapeutic approach to caring for children and young people in detention. We note that there is an existing memorandum of understanding between departments, but it is limited to delivering health services to children and young people in detention.<sup>804</sup>

The new memorandum of understanding should set out each agency’s role and responsibilities and should address assessment, case planning, case management and exit planning (discussed in Section 6.8). It should also address processes for reporting incidents, managing complaints (including those involving child sexual abuse) and resolving disputes.

### **Recommendation 12.19**

The Tasmanian Government should:

- a. establish clear processes and guidelines for assessment, case planning and case management for children and young people in detention, to enable the delivery of tailored, multidisciplinary, therapeutic responses to each child and young person as part of their daily routine, which meet their health and wellbeing needs and address the factors contributing to their offending behaviour
- b. implement a collaborative, multidisciplinary approach to responding to each child and young person in detention that includes all relevant service providers and, to the greatest extent possible, the child or young person’s family

- c. develop a memorandum of understanding between agencies involved in delivering services to children and young people in detention, including child protection, health, disability support and education that
  - i. describes the roles and responsibilities of each agency in case planning and case management
  - ii. commits to agencies adopting a collaborative, child-centred approach
  - iii. contains clear protocols for record keeping, information sharing, incident reporting and dispute resolution
- d. ensure each child or young person in detention (and/or their representative) is given the opportunity to participate in case planning and case management processes, express their views and have those views given due weight
- e. ensure each child and young person on remand has access to therapeutic services and supports, with statutory protections that prohibit using disclosures made during interventions and programs on remand as evidence of guilt.

## 6.5 Health services for children in detention

As discussed in Chapter 10, the death of a young person at Ashley Youth Detention Centre in 2010 triggered several reviews and inquiries into the Centre, including a coronial inquest. These reviews and inquiries identified problems with access to health care at Ashley Youth Detention Centre at the time and resulted in the Department initiating several positive, health-related reforms. In this section, we identify other changes that should be made to improve children and young people's access to health care in detention.

### 6.5.1 Current health services

Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that recommendations made after the death in detention were implemented by November 2013.<sup>805</sup> The recommendations included transferring the functions of the Ashley Youth Detention Centre health service to the then Department of Health and Human Services' Correctional Primary Health Services, increasing nursing capacity and establishing a health care information system to store and share all client information in one place.<sup>806</sup>

Mr Nicholson described the health services currently available to children and young people at Ashley Youth Detention Centre.<sup>807</sup> Under the supervision of a Nurse Unit Manager who is based at the Centre, Correctional Primary Health Services provide:



- an initial health assessment of a child or young person on admission to the Centre to determine the level of health care they will need while in detention<sup>808</sup>
- management of ‘active health problems including review of medications, treatment of existing conditions, drug and alcohol issues and mental health assessments’<sup>809</sup>
- drug and alcohol detoxification and relapse prevention, and management of injections, injuries and other conditions requiring low- to medium-level health care<sup>810</sup>
- outpatient allied health service referrals, including forensic mental health, physiotherapy, dental and optometry services<sup>811</sup>
- sexual health education, drug and alcohol education, immunisation and other preventive health programs.<sup>812</sup>

Nurse-led clinics staffed by 3.5 full-time-equivalent nursing staff are available from 7.00 am to 7.00 pm each day, and nurses are available on-call outside these hours.<sup>813</sup> A doctor, who also has responsibilities outside Ashley Youth Detention Centre, is available twice weekly and is on-call outside these sessions.<sup>814</sup>

Also, the Alcohol and Drug Service provides support, counselling and harm minimisation education for children and young people wanting to address their substance use.<sup>815</sup> Mr Nicholson told us that, at the time of his statement in August 2022, there was ‘no [alcohol and drug service] coverage due to shortages’ in the service.<sup>816</sup>

A forensic psychologist is based full-time at Ashley Youth Detention Centre to ‘address young people’s criminogenic needs and provide therapy’.<sup>817</sup> The forensic psychologist also ‘provides risk assessments for suicide and self-harming ideation’ and ‘education on prosocial attitudes and behaviour modification’.<sup>818</sup> In his statement, Mr Nicholson told us that this position had been vacant since November 2021.<sup>819</sup> In oral evidence, he acknowledged the challenges of recruiting to such a position—including the various employment options available to psychologists and the negative media coverage of conditions at Ashley Youth Detention Centre—but indicated that an August 2022 recruitment process for the position had been successful.<sup>820</sup>

A child psychiatrist attends Ashley Youth Detention Centre one day a month to assess, diagnose, treat and review children and young people.<sup>821</sup>

### 6.5.2 Increasing access to mental health services

We consider the level of children and young people’s access to mental health services while at Ashley Youth Detention Centre to be insufficient.

Professor Ogloff told us that, while not all children and young people in detention had ‘conventional psychiatric illness’, they all had ‘significant behavioural or mental health problems or cognitive problems that required professional intervention’.<sup>822</sup>

Mental health challenges among children and young people in the youth justice system commonly co-occur with other complex health and social problems.<sup>823</sup>

The former Head of Department for Statewide Forensic Mental Health Services highlighted the importance of having a specialist child and adolescent psychiatrist and psychologist at Ashley Youth Detention Centre:

These mental health professionals have specific training, knowledge, skills and experience regarding normal childhood development and the complexities encountered in children and adolescents with mental health conditions in addition to their offending behaviours. This includes ... specialty knowledge of mental illness, co-morbid Substance Use Disorders, +/- Intellectual Disabilities +/- Specific Learning Difficulties and trauma histories.

They are best placed to assess a young person within their developmental stage, identify their specific risk factors for problematic behaviours, and assist the [Multi-Disciplinary Team] develop and implement specific management plans to mitigate these identified risk factors and minimise problematic behaviours. These interventions are targeted at treating and managing their complex mental health conditions, comorbidities and subsequent behaviours; the focus being on attempting to change their trajectory so that they do not become involved with the Adult Criminal Justice System.<sup>824</sup>

Professor Ogloff said that psychologists at Ashley Youth Detention Centre were 'often poorly trained' to manage the complex needs of children and young people in detention.<sup>825</sup> As noted in Section 6.5.1, we heard that the position of forensic psychologist at Ashley Youth Detention Centre had been vacant for some time.<sup>826</sup>

Professor Ogloff also referred to the limited psychiatric care available at Ashley Youth Detention Centre.<sup>827</sup> The Nurse Unit Manager at Ashley Youth Detention Centre similarly commented that:

More psychiatry services at [Ashley Youth Detention Centre] would improve service delivery. [The psychiatrist] is funded for sessional work. By the time we have hand over and she goes through clinic notes it does not leave a lot of time. If she has court reports to complete as well this encroaches on her clinic time. [The psychiatrist] often has to write her clinic notes in her own time once she returns to Victoria. Fortnightly clinics would be beneficial.<sup>828</sup>

In 2018, the Custodial Inspector recommended that Ashley Youth Detention Centre 'increase the dedicated psychiatry time for young people in detention and links to external psychiatry services to assist young people on release' and 'increase the dedicated clinical psychology time for young people in detention'.<sup>829</sup>

The Director of Nursing, Statewide Forensic Mental Health Services, told us that children and young people in detention can be transferred to a psychiatric facility from Ashley Youth Detention Centre.<sup>830</sup> Under section 134A of the Youth Justice Act, the Secretary may direct that a detainee who, in the opinion of a medical practitioner or psychologist,

appears to be suffering from a mental illness be removed from a detention centre to a 'secure mental health unit' if this is in the best interests of the detainee, other detainees or staff, or if the detainee has requested to be moved to a secure mental health unit.<sup>831</sup> The Secretary must have considered a report of the Chief Forensic Psychiatrist before making such an order.<sup>832</sup>

Tasmania has one secure mental health unit—the Wilfred Lopes Centre.<sup>833</sup> This is a specialised mental health facility for adults involved with the criminal justice system (including remandees, prisoners and those found not guilty by reason of being unfit to plead), with 35 beds located near Risdon Prison.<sup>834</sup> The Wilfred Lopes Centre does not provide specialist child and adolescent mental health treatment. It is highly problematic and inconsistent with human rights standards to send children and young people from detention to a facility accommodating adult prisoners.<sup>835</sup>

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, indicated that the absence of a dedicated mental health facility for children and young people in Tasmania means youth detention is instead being used to manage children and young people with mental health problems who are engaging in offending behaviours that risk community safety.<sup>836</sup>

Professor Brett McDermott, Statewide Specialty Director, Child and Adolescent Mental Health Service, told us that proposed reforms to the Child and Adolescent Mental Health Service included establishing a dedicated adolescent and youth inpatient facility and day hospital.<sup>837</sup> The 2020 Child and Adolescent Mental Health Services Review undertaken by Professor McDermott recommended a 'discrete mental health inpatient unit for children and adolescents' as part of Stage 3 of the Royal Hobart Hospital redevelopment.<sup>838</sup>

According to the review, the new mental health inpatient unit for children and adolescents should be 'for consumers who have severe and complex mental health challenges, who often present with an acute risk to themselves or others'.<sup>839</sup> It is not clear whether this new unit would have the capacity to receive children and young people from detention under section 134A of the Youth Justice Act.

Victoria has a Custodial Forensic Youth Inpatient Unit that is a three-bed ward located on the grounds of Footscray Hospital in Melbourne, providing 'acute inpatient services through a range of therapeutic interventions and programs to young people in custody'.<sup>840</sup> This service is delivered by Orygen Youth Health.<sup>841</sup> We consider that the proposed mental health inpatient unit for children and adolescents in Hobart should similarly provide for children and young people in custody.

More broadly, we heard that there have 'traditionally been many barriers to accessing mental health services for young people involved in the youth justice system'.<sup>842</sup>

Professor McDermott told us that, as part of the proposed reforms to child and adolescent mental health services in Tasmania, a dedicated specialist Youth Forensic Mental Health Service would be created for children and young people under the age of 18 years who are involved in the youth justice system, or are at risk of becoming involved in this system.<sup>843</sup> This was also a recommendation of the 2020 Child and Adolescent Mental Health Services Review.<sup>844</sup>

The new Youth Forensic Mental Health Service would ‘offer specialist mental health assessment, treatment and support at multiple stages of a young person’s journey via a number of avenues’ and would comprise the following three elements delivered by a multidisciplinary team:

- a youth forensic ‘consultation and liaison service’ to provide services where the Magistrates Court (Youth Justice Division) exercises its power under the Youth Justice Act to adjourn a criminal proceeding to enable a child or young person who appears to be suffering from a mental illness to be ‘observed and assessed’ (among other situations)<sup>845</sup>
- a specialised multisystemic therapy program
- ‘in reach assessment and treatment for youth in or exiting youth detention’.<sup>846</sup>

It is important that services provided by the proposed Youth Forensic Mental Health Service take account of any existing mental health plan that a child or young person may have.

In oral evidence, Professor McDermott told us that the ‘in reach’ services for children and young people in youth detention would address neurological as well as psychiatric issues:

For instance, the rate of things like fetal alcohol syndrome in detention populations is actually very high. The rate of some types of genetic presentation are actually very high. The rates of ... speech and language issues and the need for remedial education are high. So, the input to [detention] will be sort of neuropsychological as well as psychiatric, and hopefully the two arms of this service will talk to each other. For instance, you could get some assessment and work in detention and then be discharged to [a community-based multisystemic therapy] team.<sup>847</sup>

Professor McDermott indicated that a pilot Youth Forensic Mental Health Service would be in operation by December 2022.<sup>848</sup> At the time of writing, we had not received any information on whether this service had begun operating.

We are encouraged by these proposed reforms to mental health support for children and young people in detention and in the youth justice system more broadly, which we consider will offer another layer of protection for children and young people who are at risk of sexual abuse in those settings.

## Recommendation 12.20

The Tasmanian Government should ensure:

- a. there are appropriate mechanisms and pathways for children in contact with the criminal justice system to be diverted to the mental health system for assessment and treatment
- b. the proposed Youth Forensic Mental Health Service provides timely referral and access to mental health treatment, care and support for children and young people when appropriate, whether they are under community-based supervision, in detention or not yet sentenced (including on remand)
- c. children and young people in detention have daily access to an onsite child and adolescent psychologist and fortnightly access to an onsite child and adolescent psychiatrist
- d. the proposed mental health inpatient unit for children and adolescents in Hobart provides for children and young people in detention.

## Recommendation 12.21

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

- a. receive a mental and physical health assessment on admission to the detention facility, and when needed while in detention
- b. have access to 24/7 medical care
- c. have a say in their mental and physical health care.

## 6.6 Education in detention

According to the Beijing Rules, the objective of detention facilities should be to ‘provide care, protection, education and vocational skills, with a view to assisting [children and young people] to assume socially constructive and productive roles in society’.<sup>849</sup> As noted, the best-performing youth detention facilities make education and training a central feature of their operating models and provide a full, structured day to keep children and young people busy. This reduces boredom, which can ‘exacerbate negative outcomes and increase [the] likelihood of negative behavioural incidents occurring’.<sup>850</sup> We also consider that engaging in education in detention is likely to be a protective factor against the risk of child sexual abuse in detention.

## 6.6.1 Ashley School

In Tasmania, most children and young people in detention have experienced significant disruptions to their schooling, with some having completely disengaged from education.<sup>851</sup> Many have a diagnosed learning disability or other learning difficulties.<sup>852</sup>

Ashley School, which is a Tasmanian Government school on the Ashley Youth Detention Centre site, opened in 1999.<sup>853</sup> School classes run from 9.00 am to 2.30 pm each weekday, and there is an expectation that children and young people will attend classes if they can.<sup>854</sup> Each class has a maximum of four students, usually with one teacher and one teacher assistant (another teacher may attend depending on availability or the needs of students on a given day).<sup>855</sup>

Samuel Baker, Principal of Ashley School, told us that the curriculum at the school is based on the curriculum in mainstream Tasmanian schools, with literacy and numeracy making up about 30 per cent of each student's classes, and the remaining time used for specialist classes such as woodwork, cooking, physical education, health, 'fit gym' (weights and conditioning), art, Aboriginal studies and 'STEM' (science, technology, engineering and mathematics).<sup>856</sup>

Mr Baker told us that each school day has a physical education component 'to negate the confines of unit life, promote a healthy lifestyle ... [and] develop social connections, team work and regulation'.<sup>857</sup> Ashley School offers no extracurricular activities outside standard school hours.<sup>858</sup>

We did not hear any evidence about vocational training programs offered to young people at Ashley School. The Custodial Inspector's 2019 *Families, Community and Partnerships Inspection Report* indicated that Ashley Youth Detention Centre had previously obtained 'start up' training from TasTAFE—such as Certificate I and II in Kitchen Operations courses—at no cost, but that these were no longer provided.<sup>859</sup> In his statement, Mr Baker referred to supporting vocational qualifications such as barista training or Responsible Service of Alcohol training for young people who did not wish to return to mainstream school after leaving detention.<sup>860</sup>

According to Mr Baker, teachers at Ashley School use a range of strategies to support student learning and create a calm and predictable classroom environment—these include individual student learning plans, high ratios of teachers to students and 'highly differentiated and individualised learning tasks'.<sup>861</sup>

Mr Morrissey described Ashley School during the time he was Commissioner for Children and Young People as 'an exemplar of high-quality teaching staff achieving good outcomes for highly disadvantaged and traumatised young people' and said that young people consistently told him 'how much they valued the school'.<sup>862</sup> Ms Phillips told us she had 'not had negative reviews about the schooling at Ashley Youth Detention Centre' from children and young people, and suggested that this was:

... largely because the learning is at their level, they are around other young people who have low literacy and [low] previous education outcomes, and that they do not feel put in the back corner or 'different'.<sup>863</sup>

The current Commissioner for Children and Young People, Leanne McLean, has observed that, while Ashley School provides a positive experience for children and young people in detention, 'many positive educational gains that are made while a young person is detained ... invariably end when they leave' because there are few or no links to education outside Ashley Youth Detention Centre.<sup>864</sup> Commissioner McLean indicated that any new custodial model must include detailed consideration of how young people can be supported to stay engaged with education once they leave detention, suggesting that much could be learned from Victoria's work on this issue (discussed in Section 6.6.3).<sup>865</sup>

### 6.6.2 Restrictions on access to education

We heard that there were restrictions on children and young people's access to some classes depending on their colour rating under the Behaviour Development Program. For example, Mr Baker told us that children and young people who were assessed as being on 'green', 'yellow' or 'orange' levels in the Behaviour Development Program were allowed to take part in 'Team Sport' on Fridays, whereas children and young people on 'red' were excluded from this activity.<sup>866</sup>

According to Mr Baker, for children and young people on 'red':

There is the option to engage in a work pack from school if that's what they'd like to do. It's not any more punitive other than they miss out. So, certainly there's no other punitive measures put in place for that young person; they still would engage with their workers back there; that could be social games, it could be some kind of sport in their courtyard, it could be table tennis, it could be lots of other things that interest that particular person individually.<sup>867</sup>

Mr Baker also stated that children and young people on 'red' were not entitled to attend woodwork, art or 'fit gym' due to 'the availability of equipment that could be used as a weapon'.<sup>868</sup> Where students were excluded from these classes, there was alternative work available for them to do in their unit with educational staff, but Mr Baker told us that students rarely take this up.<sup>869</sup> Mr Baker acknowledged that children and young people on 'red' would not receive as many hours of educational programming as those on other levels.<sup>870</sup>

As noted in Section 6.3.2, we also heard that children and young people on the Blue Program under the previous Behaviour Development System were 'fully segregated from Ashley school'.<sup>871</sup> This is discussed in detail in Chapter 11, Case study 3.

Also, a child or young person may be excluded from school if a significant incident has led to the child or young person being assessed as 'not safe to attend' school for part



of that day.<sup>872</sup> Mr Baker described this as ‘a last resort and not a punishment but an essential mitigation strategy to keep everyone safe and ensure students are regulated and able to access learning’.<sup>873</sup>

We heard that access to face-to-face schooling for children and young people at Ashley Youth Detention Centre was significantly reduced in 2022 due to staff shortages and ‘rolling lockdowns’.<sup>874</sup> During that period, Ashley School allocated staff to units for one-on-one sessions with each young person, normally for only 45 minutes or an hour per day, which is significantly less than the legal requirement that young people attend school for the whole of each school day.<sup>875</sup> Depending on the availability of youth workers to supervise in-unit schooling, Ashley School staff were sometimes only present in one unit at a time.<sup>876</sup>

We also heard that during staff shortages the allocated time for education overlapped with the limited time that young people had outside of their rooms each day. As a result, Ashley School staff could not deliver the core curriculum to some young people at all and instead engaged them in social games or specialist work in art and other areas, or left the young person alone.<sup>877</sup> Mr Baker agreed with the assertion that even if a young person engaged in schooling for the 45 minutes to an hour available during staff shortages, this was not enough to deliver the curriculum.<sup>878</sup>

Ms Phillips told us that it was her understanding that the schooling provided to young people during the staff shortages was ‘nowhere near sufficient’ and she suspected many young people in detention cannot read or do not have the capacity to learn in their units on their own.<sup>879</sup>

As noted in Section 4.7.2, lockdowns related to staff shortages continued to occur at Ashley Youth Detention Centre in July 2023, with children and young people locked in their rooms or units for up to 23 hours each day.<sup>880</sup> We discuss staff shortages in more detail in Section 4.7.2 and lockdowns in Section 9.2.

### 6.6.3 Other models of education in detention

At the secure facilities operated by the Diagrama Foundation, children and young people have a full day of education and activities every day:

Young people are involved in learning in every aspect of their day – how to get ready for the day, how to share meals together, play sports together, how to care for and decorate their environment – not just at formal classes and workshops. Supported by social educators, qualified teachers and vocational (VET) instructors there is vocational education and training as well as classes, daily sports, and constructive leisure activities – music, art, gardening, animal husbandry and cultural activities.<sup>881</sup>

Ms Campbell also referred positively to Parkville College, the school for children and young people in Victorian youth justice centres, which:

... provides education by qualified teaching staff and makes education the predominant focus within the facility. The college's foundational principles take a strengths-based approach to supporting education, with all teachers trained in trauma-informed approaches. The college delivers the Victorian Certificate of Education and Victorian Certificate of Applied Learning, which the majority of its students undertake. It also has auspice arrangements to provide vocational training.<sup>882</sup>

Parkville College also delivers the Victorian Pathways Certificate, an inclusive year 11 and 12 standards-based certificate for students who require flexibility in their educational experiences, and the Victorian Certificate of Education—Vocational Major, a vocational and applied learning program designed to be completed over a minimum of two years, which provides students with a senior secondary certificate and notes that their educational pathway was centred around vocational learning.<sup>883</sup>

Parkville College students have six hours of structured classes each weekday, including literacy, numeracy, personal development skills, physical education, art and music.<sup>884</sup> On Friday afternoons, Saturdays and during term breaks, Parkville College operates an intensive vocational education and training timetable.<sup>885</sup>

Parkville College has developed the 'Parkville College Model', which it describes as:

... a pedagogy underpinned by trauma theory, trauma-informed practice, attachment theory, culturally responsive practice, and an extensive research-base of knowledge about effective instructional practices. At the heart of the model is a critically conscious independent learner.<sup>886</sup>

The Parkville College Model articulates five practice principles that emphasise staff self-awareness and growth; strong, secure relationships and culturally safe spaces; responsive instructional practice; student empowerment and voice; and connection to community and culture.<sup>887</sup>

The Parkville Youth Justice Precinct also includes the 'STREAT café'—a partnership between Parkville College, the STREAT social enterprise and the Victorian Department of Justice and Community Safety—which delivers hospitality training and employment pathways for young people in the youth justice system.<sup>888</sup>

In addition, Parkville College has a Transitions Team, which is responsible for education transition planning for children and young people leaving detention.<sup>889</sup> This team seeks school records for each young person in detention, alerts their last known school that they are in detention, works with the young person and their parents or carers to establish educational goals, develops a student plan and an individual education plan for the young person, and engages with the young person's destination school, including alerting it of the young person's release date.<sup>890</sup>

Parkville College also operates 'O-Street', a flexible learning centre in the community that can support children and young people who have left detention to transition into mainstream schooling.<sup>891</sup>

#### 6.6.4 Proposed reforms in Tasmania

As part of its recent commitments to prioritise prevention, early intervention and diversion of children and young people from the criminal justice system, the Tasmanian Government has committed to developing and implementing an ‘alternative education model’ for children and young people whose educational needs are not being met.<sup>892</sup> Alternative approaches to be explored may include ‘continued emphasis on needs assessments and learning plans, flexible education models and vocational pathways’.<sup>893</sup>

According to the Draft First Action Plan, ‘new alternative education programs’ will be developed by 2024.<sup>894</sup> There is no discussion of whether these programs will also be delivered in detention, or what the Government’s plans for education in its proposed new detention facility are more broadly.

#### 6.6.5 Our recommendations

Education for children and young people in detention, including those on remand, is a right, not a privilege.<sup>895</sup> It should be the central feature of a young person’s experience in detention.

While we acknowledge that the safety of students and educational staff is essential, we are concerned that access to education for some children and young people at Ashley Youth Detention Centre has been unnecessarily limited by disciplinary measures imposed in response to challenging behaviours.

As discussed in Section 6.3.2, the Behaviour Development System was applied in a punitive manner, and we consider that the replacement Behaviour Development Program should not continue to be used (Recommendation 12.18). We also agree with the Northern Territory Royal Commission that any new behaviour management program or incentive system that may be adopted in future should not restrict children and young people’s access to education, physical exercise or rehabilitation programs.<sup>896</sup>

We are also highly concerned about restrictions on children’s access to education because of lockdowns relating to staff shortages. We discuss recruitment of staff in Section 4.7.2 and lockdowns in Section 9.2.

We also consider that more work is needed to support children and young people who leave detention to remain engaged with work, training or study. This is discussed in Section 6.8 in the context of exit planning and support after release from detention.

## Recommendation 12.22

The Department for Education, Children and Young People should:

- a. ensure the Youth Justice Model of Care emphasises the central importance for children and young people in detention of access to high-quality education and vocational training that is tailored to their individual learning needs and that includes learning life skills
- b. make education programs and other structured activities accessible to all children and young people in detention (including on remand)
- c. ensure a child or young person's access to educational programs or physical exercise in detention is not linked to, or limited by, their ranking in behaviour management programs
- d. develop and establish partnerships with community organisations to create employment and training opportunities for children and young people leaving detention.

## 6.7 Facilitating links to family and community

Every child deprived of liberty has the right to stay in contact with their family and with the wider community.<sup>897</sup> Children and young people in detention need to be supported to maintain or build connections to their families and communities because such connections can provide important prosocial factors to help children and young people stop offending after they are released from detention.<sup>898</sup> It is particularly important for Aboriginal children and young people in detention to maintain connections with family, community and culture—this is discussed in Section 7.3.

As noted, many children and young people in detention have a history of involvement with the child protection system. Some have been removed from their families of origin by court order and may no longer be in contact with them. For such children and young people, contact with extended family and other trusted adults while they are in detention is particularly important. Support for rebuilding connections with immediate family should also be provided, where appropriate.

The primary mechanisms to enable children and young people in detention to stay connected to their families and communities are visits, temporary leave and phone calls.

## 6.7.1 Visits

*Standard Operating Procedure No. 9* for Ashley Youth Detention Centre states that:

- all children and young people have the right to regular contact with identified family members, ‘significant others’ such as partners and children, members of the community and professionals such as lawyers<sup>899</sup>
- management can refuse a visit if it believes that the ‘security, safety or good order of the Centre or the health or well-being of the young person may be adversely affected by allowing the visit’<sup>900</sup>
- when visits are not approved, the young person must be advised of the situation, including the reasons for non-approval<sup>901</sup>
- visits last 45 minutes and must be supervised closely by staff at all times unless approval has been given for an alternative form of supervision.<sup>902</sup>

The *Inspection Standards for Youth Custodial Centres in Tasmania* state that visits must not be ‘withheld as a sanction as part of any behaviour management regime’.<sup>903</sup>

The Custodial Inspector’s 2019 *Families, Community and Partnerships Inspection Report* found that, although Ashley Youth Detention Centre staff did not actively ‘pursue’ families and friends to visit children and young people in detention or review the frequency of visits to individual children and young people, the Centre’s facilitation of visits by family and friends was ‘commendable’.<sup>904</sup> However, the Custodial Inspector also observed that the visit room was ‘sparse’ and there were no outside facilities for visits or play areas for young children, recommending that the visiting facilities be updated to ‘make visits more relaxed and family friendly’.<sup>905</sup>

The Department told us of infrastructure upgrades to Ashley Youth Detention Centre since the Custodial Inspector’s 2019 report was published, which have resulted in a ‘softening’ of the visitors’ entrance and a new purpose-built visit room with an adjacent covered outdoor area with a barbecue.<sup>906</sup>

We heard of two occasions in 2019 where Aboriginal young people in detention were denied visits that were therapeutically important for them (discussed in Section 7.3.3).<sup>907</sup>

The Custodial Inspector’s 2019 report stated that ‘there was nothing to indicate to the inspection team that visits are ever withheld, or used as a tool to manage the young person’s behaviour’.<sup>908</sup>

As discussed in Chapter 10, Ashley Youth Detention Centre is in a location that is not accessible for many families. Upon induction to the Centre, children and young people are advised that if their family cannot afford to travel to Ashley Youth Detention Centre to visit, management can help with travel costs.<sup>909</sup> We did not hear whether families had been provided with such support in practice.

## 6.7.2 Temporary leave

Temporary leave can be used to ease a child or young person's transition into the community after release by enabling 'visits to specialist service providers within the community, and activities to maintain their connection to family'.<sup>910</sup> Exit planning is discussed in Section 6.8.

*Standard Operating Procedure No. 22* provides for temporary leave from Ashley Youth Detention Centre for children and young people.<sup>911</sup> It states that all temporary leave applications must undergo a thorough risk assessment and be approved by the Centre Manager.<sup>912</sup> Risk factors to be considered include the nature of the young person's offending, the young person's 'behaviour and attitude at or near the time of the proposed leave', any history of threats or attempts to abscond, and the young person's 'recent and current colour status' under the Behaviour Development Program.<sup>913</sup>

## 6.7.3 Phone calls

As part of their induction to Ashley Youth Detention Centre, children and young people are told that they are allowed to make seven phone calls each week.<sup>914</sup> Phone calls are no longer than 10 minutes long.<sup>915</sup> Children and young people are entitled to extra calls if they achieve 'yellow' or 'green' status in the Behaviour Development Program.<sup>916</sup>

In 2019, the Custodial Inspector recommended that the (former) Department of Communities consider 'implementing video visits for young people at [Ashley Youth Detention Centre] by means of communication tools such as Skype and FaceTime to further facilitate family and community contact'.<sup>917</sup> On our site visit to Ashley Youth Detention Centre we were told that there was no FaceTime in the visitors' room and families often did not use Zoom. We also observed a small screen on the wall in the visitors' room at a height that would have been uncomfortable for either sitting or standing. We were also told that there were problems with internet connectivity at the Centre.

## 6.7.4 Practice improvements

One of the practice principles in the Ashley Youth Detention Centre Practice Framework is to 'provide opportunities for young people, their families and communities to connect and support to heal and strengthen relationships'.<sup>918</sup> As noted in Section 6.3.3, the Practice Framework is under review.

According to the Keeping Kids Safe Plan, the Government has (as noted in Section 6.7.1) 'soften[ed]' the entrance to Ashley Youth Detention Centre, created a new reception area for visitors and improved visitor and family spaces.<sup>919</sup>

In June 2023, the Department informed us that it had 'recently procured mobile phones for young people within Ashley Youth Detention Centre', which would give them 'the

ability to make personal and professional calls from the privacy of their bedrooms or the Centre's outside spaces or meeting rooms, outside of school hours'.<sup>920</sup> The mobile phones were expected to be provided to children and young people in July 2023.<sup>921</sup> We welcome this initiative. However, we did not receive information or guidelines on the proposed use of the mobile phones by children and young people in detention.

### 6.7.5 Our recommendations

More needs to be done to enable children and young people in detention to build and maintain connections with their families and communities. This is 'a key aspect of a therapeutic model of care'.<sup>922</sup> In our view, the Department should develop a policy on supporting children and young people in detention to remain connected to their families and communities via visits, temporary leave and phone and video calls. There should be no restrictions on contact between children and young people and their families arising from security classifications or rankings in behaviour management systems.<sup>923</sup>

We consider that, overall, moving the detention facility to Hobart will increase accessibility for family and friends. However, there will still be challenges for some families (such as those living in very remote areas) to visit children and young people in detention. In these circumstances, the Government should help family members or Aboriginal community members to visit children and young people in detention.

We also recommend in Section 6.1 that any new youth detention facility in Tasmania be designed to facilitate and promote connections between children and young people, and their families and communities (Recommendation 12.16).

We consider technology-facilitated family contact to be a practical suggestion to enhance children and young people's connection with their families. We recognise that children and young people in detention are more likely to have complex family structures such as separated parents and siblings living away from one or both parents, including in out of home care. Unlimited technology-facilitated access to family is an important aspect of any strategy designed to maintain and strengthen family connection for children and young people in detention.

Finally, we note Mr McGinness's suggestion that there may be opportunities for families and communities to become involved with service delivery in youth detention.<sup>924</sup> We agree that this should be explored.



## Recommendation 12.23

The Department for Education, Children and Young People should:

- a. develop and implement a policy that recognises the importance to children and young people in detention of maintaining or building connections with their family and community and
  - i. specifies ways to promote such connections, including through visits, temporary leave and phone or video calls
  - ii. clearly states that entitlements to visits, temporary leave and phone or video calls cannot be denied on the basis of a child or young person's behaviour
- b. provide reasonable assistance (including financial help) to members of a child or young person's family or Aboriginal community to enable them to visit the child or young person frequently, where families or Aboriginal community members have barriers to accessing the youth detention facility.

## 6.8 Exit planning and support after release

Effective youth justice systems prioritise exit or transition planning and continuity of care following a young person's release from detention, often referred to as 'throughcare' services. The Northern Territory Royal Commission observed that:

A well-planned and supported transition from detention can be the circuit-breaker in a cycle of reoffending. Without adequate planning for release, the system is [setting a young person up to fail]. Without post-release support, the likelihood of failure inevitably increases.<sup>925</sup>

The Northern Territory Royal Commission recommended establishing 'an integrated, evidence-based throughcare service' for children and young people in detention in the Northern Territory to deliver:

- adequate planning for release—including safe and stable accommodation, access to physical and mental health support, access to substance abuse programs and assistance with education and/or employment—with planning to start on entry into detention
- improved post-release services to be made available to all children and young people detained more than once or for longer than one week
- a comprehensive wraparound approach facilitated by cross-agency involvement.<sup>926</sup>

Mr McGinness similarly endorsed the notion of commencing exit planning ‘from the moment a young person comes into custody’, creating links to community-based service providers and families, and actively supporting young people in their transition back into the community.<sup>927</sup> He also referred to the benefits of an ‘integrated model’ that would allow:

... caseworkers and youth justice personnel to assist [young people] in building connections with educators outside the youth justice system, so that the young person can maintain this relationship once they leave detention. The same concept applies to health services, such as psychologists and occupational therapists. Integrated Through Care delivered under a therapeutic justice model ensures continuity of care when a young person’s detention ends.<sup>928</sup>

### 6.8.1 Exit planning and post-release support in Tasmania

Ashley Youth Detention Centre has a procedure on exit planning for children and young people that provides that:

- Wherever possible, exit planning must begin six weeks before the young person’s earliest release date, and where this is not possible, it must begin ‘with sufficient time to engage all relevant stakeholders and develop a formal plan’.<sup>929</sup>
- Exit planning meetings must identify services and supports that ‘may enhance the young person’s capacity to reintegrate into the community and reduce the risk of reoffending’ and set out ‘appropriate goals and case planning strategies to assist the young person reduce the risk of reoffending’.<sup>930</sup>
- While exit planning is to be coordinated by Ashley Youth Detention Centre case management staff, a Community Youth Justice worker must take part in exit planning meetings. Their role is to ‘assist in the exit planning process’.<sup>931</sup>
- If the young person is subject to a child protection order, ‘a Child Protection Worker’ must be invited to take part in exit planning.<sup>932</sup>
- The young person’s nominated parent, carer or guardian must be contacted and invited to attend exit planning meetings. Where this is not possible or appropriate, the young person’s case manager and nominated Community Youth Justice worker must ‘endeavour to identify and engage an appropriate and meaningful adult to support and assist the young person through the exit planning process and upon release from custody’.<sup>933</sup>

The exit planning procedure also states that, when a young person is not released under community supervision, ‘every effort will be made in the exit planning process to connect the young person to a community organisation for support upon release’.<sup>934</sup>

The exit planning procedure does not indicate how the various other services required to support a child or young person in the community are to be involved in the exit planning process. We also note that the procedure requires ‘a Child Protection Worker’—rather than the young person’s current child protection worker, or one who knows the young person and their circumstances—to be ‘invited to participate’ in exit planning, suggesting that their attendance is not strictly required. This is problematic, given that some young people are released from detention without stable accommodation, which increases their risk of returning to detention.<sup>935</sup>

We heard that there was a lack of effective throughcare support for children and young people leaving detention in Tasmania.<sup>936</sup> Vincenzo Caltabiano, former Director, Tasmania Legal Aid, told us that children and young people needed more help to re-establish their lives following release from detention, as many find themselves returning there within 12 months of release.<sup>937</sup>

Similarly, Adjunct Associate Professor Mitchell told us that children and young people face various challenges on release from detention, noting that ‘anecdotally ... a lot of kids will offend again to get back to Ashley, because it’s the closest thing to a bed and food that they have’.<sup>938</sup> We heard similar comments from participants in our consultations with Aboriginal communities, which we discuss in Section 7.4 on the lack of post-release support for Aboriginal children and young people.

Commissioner McLean has advocated for continuity of support for detained children and young people who are involved in the out of home care system. She has noted that:

... there are some contractual arrangements that can prevent the provision of supports being continued by non-government providers once a young person is on a detention order and housed at [Ashley Youth Detention Centre].<sup>939</sup>

Also, as outlined in Section 6.6.1, Commissioner McLean has observed that substantial work needs to occur in Tasmania to ensure children and young people who leave detention stay connected to education.

Save the Children’s Transition from Detention program is a voluntary mentoring program for children and young people leaving detention in Tasmania that ‘bridges the gap between the detention centre and outside services that are not funded or are unable to provide services within the centre’.<sup>940</sup> According to Commissioner McLean, children and young people leaving detention ‘value being able to participate in pro-social activities as part of this program’, but current resourcing for the program has limited the ability of youth workers to attend Ashley Youth Detention Centre and engage with young people there.<sup>941</sup>

In its submission to the Tasmanian Government on the proposed youth justice reforms, Save the Children advocated for service providers to be granted greater access to detention centres throughout a young person’s period in custody, ‘so they can build trust and commence sustainability planning as early as possible’.<sup>942</sup>

## 6.8.2 Practice improvements

Strategy 4 of the Draft Youth Justice Blueprint is to ‘integrate and connect whole of government and community service systems’.<sup>943</sup> An aim of this strategy is to achieve:

... a throughcare approach for children and young people that facilitates and supports transition between services, facilities and the community in a responsive and children and young person-centred manner.<sup>944</sup>

The Draft Youth Justice Blueprint adopts a broader approach to ‘throughcare’ than one focused solely on leaving detention:

A throughcare approach that commences service planning at the earliest possible opportunity and follows the young person’s engagement with youth justice services can provide stability for the young person. Consistent case management and client centred planning across the continuum, as well as ongoing access to support services with whom the young person is engaged enables the development of rapport and stability that is not dependent upon the young person’s place within the continuum i.e., detention.<sup>945</sup>

Also, as noted in Section 2, the Tasmanian Government has announced it will establish two supported residential facilities as part of the suite of facilities that will replace Ashley Youth Detention Centre.<sup>946</sup> One pathway into this type of facility will be where the child or young person has left detention on a supervised release order with a condition to ‘attend’ the supported residential facility.<sup>947</sup> It would appear that the Government anticipates these facilities could serve as temporary or transitional accommodation for children and young people released from detention.

As noted in Section 6.6.4, the Government has also committed to developing new alternative education programs by 2024.<sup>948</sup> It is possible that these could be accessed by children and young people following their release from detention, but the Government’s documentation does not specifically address this.

## 6.8.3 Our recommendations

The Government’s proposed reforms to support children leaving detention are welcome. The proposed supported residential facilities are also promising, but more detail is needed about how they will operate to support children and young people after their release.

There is an immediate and urgent need for housing, mental health, education and other support for children and young people leaving detention. As discussed in Section 7.4, there is a particularly urgent need for post-release support for Aboriginal children and young people. We consider that the Government should prioritise developing effective, coordinated exit planning and post-release support services for children and young people leaving detention. This should be addressed in the Youth Justice Model of Care

for detention recommended in Section 6.3.4 (Recommendation 12.18). Throughcare support services must be culturally safe for Aboriginal children and young people and respond to their needs (refer to the discussion in Section 7.4).

We agree with Save the Children's call for community-based post-release service providers to have greater access to detention centres throughout a young person's period in custody to build trust with the young person and start planning for post-release as early as possible.

Providing exit planning and post-release services for children and young people should be supported by a comprehensive exit planning procedure and a memorandum of understanding that specify clear requirements for how the various services required to support an individual young person in the community must work together to ensure the young person has stable accommodation, links to education or work, and ongoing support for mental health, disability and other needs.

There is a particularly urgent need for coordination and collaboration with child protection services. Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre in the Australian Capital Territory, referred to the model of 'single case management' provided by Child and Youth Protection Services, whereby children and young people under the guardianship of the state have the same case manager in the youth justice system, whether under community-based supervision or in custody.<sup>949</sup> She said this provided 'a consistent voice and seamless service delivery to young people throughout their involvement in the youth justice system'.<sup>950</sup> We consider that such an approach could have considerable benefit in Tasmania.

Considerable work is also needed to meet the educational needs of children and young people following their release from detention. In this respect, we note the benefits of schools such as Parkville College in Victoria (discussed in Section 6.6.3), whose Transitions Team supports children and young people to move from education in detention to education in the community, and the Berry Street School—a specialist independent school with four campuses across Victoria that offers a flexible and individualised learning approach and a transition program for students who have been excluded from education and who need support to re-engage.<sup>951</sup> We consider that engagement in education is a protective factor against child sexual exploitation in the community.

## Recommendation 12.24

The Tasmanian Government should:

- a. establish an integrated throughcare service for children and young people in detention that
  - i. begins exit planning as soon as possible after a child or young person enters detention for the provision of safe and stable accommodation, access to physical and mental health support, and assistance with education or employment after release to facilitate their reintegration into the community
  - ii. provides increased access to the detention facility for staff of community-based providers of post-release services
  - iii. adopts a collaborative, child-centred, cross-organisation approach involving child protection, housing, health, disability support and education services, supported by a memorandum of understanding and clear policies and procedures
  - iv. involves the child or young person and, to the greatest extent possible, their parent, guardian or other significant adult in exit planning
  - v. includes post-release wraparound support services for children and young people
  - vi. is culturally safe for Aboriginal children and young people
- b. deliver community-based schooling options for children and young people with complex behavioural challenges, including those who are or have been involved in the youth justice system, to provide appropriate learning environments for children to transition to when they leave detention.

## 6.9 Transfers to prison

Children and young people may be detained in an adult prison facility or transferred from Ashley Youth Detention Centre to an adult prison facility in certain circumstances. The Youth Justice Act states that a child or young person under the age of 19 years who is refused bail can be detained in an adult prison facility if the Secretary of the Department for Education, Children and Young People determines it is not practicable to detain them in a youth detention centre.<sup>952</sup>

In this section, we focus on the transfer of children and young people from Ashley Youth Detention Centre to the adult prison system. While we have not examined the use of the Secretary's discretion under the Youth Justice Act to detain a young person in an

adult prison facility at the time they are refused bail, we encourage the Government to consider our recommendation in relation to transfers broadly and implement it consistently in relation to all avenues by which children and young people may be detained in adult facilities.

The Youth Justice Act does not specify a process for transfers; rather, they are managed administratively under a memorandum of understanding between the former Department of Health and Human Services and the Department of Justice.<sup>953</sup> The Manager of Ashley Youth Detention Centre can make a request to the Director of the Tasmania Prison Service to transfer a child or young person to a Tasmania Prison Service facility.<sup>954</sup> The Director may agree to accept the child or young person for a specified period.<sup>955</sup>

According to the memorandum of understanding, a transfer to prison may be appropriate for a child or young person requiring a ‘high level of secure care’, where:

Secure care relates to the level of security required as a result of the low level of pro social behaviour demonstrated by the youth. These youths may be described as high risk/high needs.<sup>956</sup>

Under the memorandum of understanding, grounds for transferring a child or young person from detention to prison include:

- that the child or young person represents a high risk to the safety and security of themselves, other children and young people, staff, visitors, the facility or ‘day to day management and operations of the site’<sup>957</sup>
- ‘special reasons’ listed in Schedule 2—these include ‘[v]iolence, disruptive behaviour or behaviour issues unable to be treated on site’, ‘escape attempts and actual escape’ and ‘serious detention centre offences’<sup>958</sup>
- that the child or young person requires specialist assessment or treatment not available outside major urban areas.<sup>959</sup>

Where a child or young person is transferred to prison for more than 14 days, a ‘Transfer Assessment Panel’ is convened to review the transfer and determine whether it should be continued.<sup>960</sup> This panel includes representatives of the Tasmania Prison Service, Youth Justice Services (including professional services staff from Ashley Youth Detention Centre) and Correctional Primary Health Services, but it does not include an oversight body or anyone who is independent of government.<sup>961</sup>

A transfer to prison may be continued where the Transfer Assessment Panel classifies the child or young person as ‘[n]ot benefiting from the Behavioural Development Program and [Ashley Youth Detention Centre] case management model’ and as being ‘not suitable for detention’ at the Centre, having regard to several criteria.<sup>962</sup> These include age, gender, cultural background, ‘security and safety assessment’, ‘level of social responsibility’, the number and nature of incidents the young person has been



involved in, and whether their behaviour indicates they are ‘likely to create a serious management problem’ at the Centre.<sup>963</sup> The criteria do not include the best interests of the child or young person.

This process can be contrasted with the process for transferring children and young people from youth detention to an adult prison in other jurisdictions. For example, in Victoria, the *Children, Youth and Families Act 2005* (Vic) gives the Youth Parole Board the power, on the application of the Secretary of the Department of Justice and Community Safety, to direct that a young person who has been sentenced to detention in a youth justice centre be transferred to a prison.<sup>964</sup> The Youth Parole Board is chaired by a judge of the County Court of Victoria and includes two people with ‘experience in matters relating to child welfare’.<sup>965</sup>

In determining whether to make a direction to transfer a young person, the Victorian Youth Parole Board must consider ‘the antecedents and behaviour of the person’, their age and maturity, as well as a report from the Secretary that sets out the steps that have been taken to avoid the need for the transfer to prison.<sup>966</sup> The Youth Parole Board must also be satisfied that the young person has ‘engaged in conduct that threatens the good order and safe operation of the youth justice centre’ and ‘cannot be properly controlled in a youth justice centre’.<sup>967</sup>

In Victoria, only young people aged 16 years or older can be transferred to prison, unlike in Tasmania, where there do not appear to be any age limits on the transfer of children and young people.<sup>968</sup>

We did not request or receive any evidence on the frequency of transfers from Ashley Youth Detention Centre to adult prison facilities. However, in Chapter 11, Case study 2, we find that Ashley Youth Detention Centre was not equipped to meet the complex needs of children and young people, resulting in at least one being transferred to adult prison.

Housing children and young people with adults in the criminal justice system is contrary to international human rights instruments (discussed throughout this chapter). Children and young people with challenging behaviours and complex needs—particularly cognitive disabilities—are highly vulnerable to abuse, including child sexual abuse, in prison.

We are deeply concerned that children and young people can be transferred from youth detention to adult prison in Tasmania without any oversight from a court, tribunal, parole board or other independent body. We are also concerned that a child or young person can be transferred solely for operational reasons, or based on the young person’s complex and difficult behaviours, without considering their best interests or the likely impact on them of being transferred to prison. This approach fails to recognise the effects of trauma on children and young people’s ability to regulate their emotions and behaviour. It risks children and young people who have been abused or who have

experienced neglect or other adverse childhood experiences feeling as though others consider they are beyond help. It may have the effect of punishing them for the failure of the youth justice system to support them to address their challenges.

As discussed in Section 6.3, we do not consider the Behaviour Development Program to be an appropriate or effective tool for responding to children and young people's complex behaviours in detention. A child or young person's failure to 'benefit' from this program is therefore not an appropriate basis upon which to transfer them to prison or to decide to keep them in a youth detention facility. We recommend that this program be discontinued in youth detention (Recommendation 12.18).

We recommend that the Tasmanian Government adopts a new process for managing transfers from youth detention, requiring approval from a body that is independent of government. Given Tasmania does not have a youth parole board, we recommend that the Department for Education, Children and Young People be required to seek approval from the Magistrates Court for any transfers. In Section 5.5.6, we recommend establishing a new specialist division of the Magistrates Court to hear child protection matters and children's criminal matters. Applications for transfers from detention to prison should be made to a magistrate of this new division, and until this division is established, to a magistrate of the Youth Justice Division.

Transfer applications should only be made in respect of young people aged 16 years or older. In determining whether to approve a transfer, the Magistrates Court should be required to consider (among other matters):

- what steps the Department has taken to avoid the need for the transfer
- whether the transfer is in the young person's best interests
- the views of the new Commission for Children and Young People (Recommendation 18.6) on the appropriateness of the transfer.

The Department should be required to notify the Commission for Children and Young People of any proposed transfer.

Also, we are concerned about the transfer to prison of young people aged 18 years or older who are serving their sentence in youth detention. Young adults are extremely vulnerable in prison. The Victorian Ombudsman has noted that 'young prisoners are at significant risk of post-traumatic stress disorder arising from the conditions of their detention, and at high risk of rape and assault from older prisoners'.<sup>969</sup>

In a 2019 report on the sentencing of young adult offenders, the Victorian Sentencing Advisory Council stated that:

... holding young adults in adult prisons can be counterproductive to their treatment and rehabilitation. It can expose them to harms (such as risks to their safety from older adults) and can restrict their participation in mandatory prosocial, constructive activities that are typically available in youth-focused facilities (such as improved educational opportunities, targeted programs and specialist transition resources). This poses risks to the community, which is better served by approaches that maximise the potential for an offender's rehabilitation.<sup>970</sup>

The Tasmanian Government should consider allowing vulnerable young people aged 18 years or older who are serving their sentence in youth detention to stay in detention rather than being transferred to an adult prison. This would be consistent with broader trends to increase the age limit on services for vulnerable young people beyond 18 years—for example, extending out of home care services to the age of 21 years.<sup>971</sup>

### **Recommendation 12.25**

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

- a. limits transfers to young people aged 16 years or older
- b. requires the Department for Education, Children and Young People to notify the Commission for Children and Young People (Recommendation 18.6) of any proposed transfer
- c. requires the Department to apply to the Magistrates Court (Youth Justice Division) or the new specialist children's division of the Magistrates Court (Recommendation 12.15) for approval to transfer
- d. requires the Magistrates Court, in determining whether to approve the transfer, to consider, among other matters, the steps the Department has taken to avoid the need for the transfer, whether the transfer is in the young person's best interests and the views of the Commission for Children and Young People on the appropriateness of the transfer.

## **6.10 Auditing custodial periods**

In 2016, the Tasmanian Government issued a media release stating that prisoners had been released from Risdon Prison on the incorrect date on seven occasions due to 'administrative errors when dealing with and interpreting warrants issued by the Courts'.<sup>972</sup> These errors were said to be 'the result of long-term process issues within the Justice system', 'a heavy reliance on paper based forms used in Court operations' and the manual calculation of release dates by the Tasmania Prison Service.<sup>973</sup>

In 2021, a media report indicated that, in the preceding four years, nine prisoners had been released from Risdon Prison before or after their release dates.<sup>974</sup> We heard of similar concerns about youth detention from a former employee of the Department.<sup>975</sup>

In June 2023, the Department informed us that magistrates now calculate each young person's 'earliest release date'.<sup>976</sup>

We would be extremely concerned if children and young people were being detained for longer than is required by their custodial orders. The Government should take steps to ensure this is not occurring.

### **Recommendation 12.26**

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

## **7 Aboriginal children in youth detention**

Aboriginal children and young people are vastly over-represented in Tasmania's youth justice system, particularly in youth detention. We understand this to be a direct and continuing impact of colonisation. As one participant in our consultations with Aboriginal communities told us, youth detention creates lasting damage for Aboriginal children and young people:

A very high percentage of our young people have been to Ashley. Those young people then started getting into trouble as adults. Once they came out [of Ashley Youth Detention Centre], they should have been proud of who they are and have aspirations of what they want to do, but they were so mistreated in there. It's another layer of abuse—layer upon layer upon layer.<sup>977</sup>

According to data published by the Australian Institute of Health and Welfare, on an average day in youth detention in Tasmania in 2021–22, Aboriginal children and young people aged 10 to 17 years accounted for 44 per cent of the detention population (sentenced and unsentenced) in that age group, despite constituting 10 per cent of all Tasmanian children and young people aged 10 to 17 years.<sup>978</sup> This figure is broadly consistent with what we heard in evidence.<sup>979</sup>

Aboriginal children and young people are similarly over-represented in the remand population. On an average day in youth detention in Tasmania in 2021–22, 42 per cent of children and young people aged 10 to 17 years on remand were Aboriginal.<sup>980</sup>

Aboriginal children and young people are also over-represented among children and young people who are known to the child protection and youth justice systems—known as ‘crossover children’.<sup>981</sup> As noted in Section 5.5.3, Tasmania Legal Aid’s 2021 *Children First* report—which examined how many of its clients had both a child safety file and a youth justice file—found that 15 per cent of children in this category identified as Aboriginal.<sup>982</sup>

According to the National Royal Commission, research shows that the over-representation of Aboriginal children and young people in youth detention in Australia is a result of ‘historical factors, systemic racism, policing practices and a range of socioeconomic factors’.<sup>983</sup>

Similarly, in its 2021 *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that the over-representation of Aboriginal children and young people in Victoria’s youth justice system stemmed from colonisation, dispossession, the forced removal of children from their families, broken connection to Country and culture, intergenerational trauma, over-policing, systemic racism in service systems and ongoing government intervention in Aboriginal people’s lives.<sup>984</sup> These factors can cause Aboriginal families to experience poverty and socioeconomic disadvantage, housing instability, low educational attainment, mental illness, drug and alcohol misuse, family violence and intergenerational cycles of child protection involvement, each of which increases the risk that a child will enter the youth justice system.<sup>985</sup>

The National Royal Commission observed that, while Aboriginal children were not inherently more vulnerable to child sexual abuse in institutions than non-Aboriginal children, Aboriginal children were:

... more likely to encounter circumstances that increased their risk of abuse in institutions, reduced their ability to disclose or report abuse and, if they did disclose or report, reduced their chances of receiving an adequate response.<sup>986</sup>

Reducing the number of Aboriginal children and young people in Tasmania’s youth justice system is essential to minimising the risk they will experience child sexual abuse in detention. The 2020 *National Agreement on Closing the Gap* aims to reduce the rate of Aboriginal children and young people in detention by at least 30 per cent by 2031 (Target 11).<sup>987</sup> The Tasmanian Government has committed to two actions to meet this target: a focus on police diversion and building partnerships with Aboriginal people. But much more needs to be done.<sup>988</sup>

The Draft Youth Justice Blueprint (outlined in Section 2.2) is promising in its references to prevention, early intervention and diversion as strategies to ‘change[e] the pathways for children and young people at risk of, or who are engaged in offending behaviours’.<sup>989</sup> However, there is scope for a greater focus on the specific needs of Aboriginal children and young people in this blueprint.

In Section 5, we make several recommendations covering all children and young people in detention that would contribute to achieving Target 11, namely:

- increasing the minimum age of criminal responsibility to 14 years and working towards increasing the minimum age of detention to 16 years (Recommendation 12.11)
- increasing pre-court diversion opportunities for children and young people (Recommendation 12.13)
- strengthening the bail system to increase the likelihood that children and young people charged with criminal offences will receive bail and comply with their bail conditions, and to reduce the number of children and young people on remand (Recommendation 12.14)
- ensuring sentencers have an appropriate hierarchy of community-based sentencing options, so detention is an option of last resort (Recommendation 12.15).

Further, in Chapter 9, we recommend changes to reduce the number of Aboriginal children entering the out of home care system, including more investment in Aboriginal-led targeted early intervention and prevention services for Aboriginal families (Recommendation 9.15). Improved support for Aboriginal families will also help reduce the number of Aboriginal children and young people entering the youth justice system.

In this section, we also recommend that the Tasmanian Government develops an Aboriginal youth justice strategy to ensure its proposed reform of the youth justice system includes a strong focus on the needs of Aboriginal children and young people and their families. This strategy should be founded on the principle of self-determination, and it should commit to actions that will prevent Aboriginal children from entering the youth justice system and divert them from detention.

For Aboriginal children who experience youth detention, the National Royal Commission recommended that state and territory governments consider strategies that would provide for their cultural safety, including:

- recruiting and developing Aboriginal staff to work at all levels of the youth justice system, including in key roles in complaints-handling systems
- ensuring all youth detention facilities have culturally appropriate policies and procedures that facilitate connection with family, community and culture, and reflect an understanding of, and respect for, cultural practices in different clan groups
- employing, training and professionally developing culturally competent staff who understand the particular needs and experiences of Aboriginal children, including the specific barriers that Aboriginal children face in disclosing sexual abuse.<sup>990</sup>

The Tasmanian Government is yet to fully implement this recommendation.

On the contrary, the evidence we received raises our concerns about cultural safety for Aboriginal children and young people in Ashley Youth Detention Centre. We heard that some Aboriginal children and young people received little or no cultural support in detention and, in some cases, were denied contact with family or community members.<sup>991</sup>

The Tasmanian Government has made announcements about the facilities that will replace Ashley Youth Detention Centre, but it has given little attention to the needs of Aboriginal children and young people in these announcements.<sup>992</sup> Similarly, the Keeping Kids Safe Plan does not refer to Aboriginal children and young people or include any specific plans to ensure their safety.<sup>993</sup>

It is important that any new facilities be co-designed with Aboriginal communities to ensure they are culturally safe and enable Aboriginal children and young people to connect with family, community and culture. However, Ashley Youth Detention Centre also needs to be culturally safe while it continues to operate.

Accordingly, in this section, we make recommendations for improving the cultural safety of Aboriginal children and young people who are remanded or sentenced to youth detention, covering:

- cultural support for Aboriginal children and young people in detention, including regular contact with family and community members, and access to cultural programs
- the recruitment of Aboriginal staff to support Aboriginal children and young people in detention
- appropriate professional development for staff of youth detention facilities to ensure they are aware of the unique experiences and needs of Aboriginal children and young people.

We also discuss support for Aboriginal children and young people leaving detention.

## 7.1 An Aboriginal youth justice strategy

As noted, Aboriginal children and young people are more likely than non-Aboriginal children and young people to encounter circumstances that increase their risk of abuse in institutions, including youth detention. It is therefore incumbent on the Tasmanian Government to take active steps to limit Aboriginal children and young people's entry into youth detention. This requires a commitment to prevention, early intervention and diversion strategies focused on Aboriginal children and young people and their families. As one participant in our consultations with Aboriginal communities told us:

What about diversion programs rather than going to detention? To me it was pivotal that I went to a diversion program with Aboriginal Elders, instead of going to Ashley for 12 months. If I had been in there it would have changed my life in terrible ways, instead I got to stay with community and it helped me.<sup>994</sup>



As described in Section 2.2, the Draft Youth Justice Blueprint identifies five strategies of focus from 2022 to 2032. They are to:

- prioritise prevention and early intervention to reduce engagement with the youth justice system
- ensure diversion from the justice system is early and lasting
- ensure a therapeutically based criminal justice response for children and young people
- integrate and connect whole of government and community service systems
- provide an appropriately trained and supported ‘therapeutic workforce’.<sup>995</sup>

Some of these strategies include specific goals for Aboriginal children and young people. For example, the Draft Youth Justice Blueprint aims to:

- support Aboriginal communities to develop programs that promote wellbeing and sustain connectedness with community and culture<sup>996</sup>
- ensure Aboriginal children and young people have access to Aboriginal-led diversionary services<sup>997</sup>
- provide Aboriginal children and young people with therapeutic responses that meet their needs<sup>998</sup>
- increase ‘cultural competence across the youth sector to enable staff to identify and work in culturally appropriate ways’ to support and respond to the needs of Aboriginal children and young people in the youth justice system.<sup>999</sup>

These goals are positive. However, they are general and do not identify specific actions to achieve them.

The Draft First Action Plan acknowledges that the approach to diverting Aboriginal children and young people from the youth justice system may be different from general diversionary processes. It states that engagement with Aboriginal children, young people and communities will be essential to ensure culturally safe, Aboriginal-led diversion services.<sup>1000</sup> The Draft First Action Plan also indicates that the proposed Youth Justice Model of Care (discussed in Section 6.3) will be co-designed with Aboriginal communities.<sup>1001</sup>

In February 2022, the Victorian Government published *Wirikara Kulpa*, Victoria’s Aboriginal youth justice strategy, whose development was led by Victoria’s Aboriginal Justice Caucus.<sup>1002</sup> The strategy is underpinned by Aboriginal self-determination and has a series of guiding principles, which are to:

- amplify the voice and participation of Aboriginal children and young people, and promote and protect their rights

- value the strengths of Aboriginal children and young people
- support child- and family-centred approaches
- embed trauma-informed healing approaches
- centre Aboriginal cultural values and connection.<sup>1003</sup>

*Wirkara Kulpa* identifies five key priorities or ‘domains’ for 2022 to 2032—including diverting Aboriginal children and young people from the youth justice system, addressing over-representation and working towards Aboriginal-led justice responses—and commits to more than 70 actions across these domains.<sup>1004</sup>

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that services designed, controlled and delivered by the Aboriginal community have the greatest potential to produce the best outcomes for Aboriginal children and young people.<sup>1005</sup> Aboriginal communities in Tasmania told us that Aboriginal input into services for and decisions about Aboriginal children and young people is essential.<sup>1006</sup>

We consider that the Tasmanian Government should build on the commitments in its Draft Youth Justice Blueprint by developing an Aboriginal youth justice strategy in partnership with Aboriginal communities. In its submission to our Commission of Inquiry, the Tasmanian Aboriginal Legal Service recommended creating such a strategy.<sup>1007</sup> A carefully and collaboratively developed Aboriginal youth justice strategy would help the Tasmanian Government to achieve its goal of reducing Aboriginal over-representation in youth detention in line with Target 11.

The development of the Aboriginal youth justice strategy must be led by Aboriginal communities across Tasmania and underpinned by the principle of self-determination in the youth justice system, whereby Aboriginal communities have authority in respect of Aboriginal children and young people. We note that the Draft Youth Justice Blueprint refers to an ‘increased focus on self-determination’ and commits to partnering with Aboriginal communities to determine the most appropriate responses to address Aboriginal over-representation in the youth justice system.<sup>1008</sup> The Tasmanian Government should ensure Aboriginal communities and organisations are supported and resourced to participate in developing the Aboriginal youth justice strategy.

The Aboriginal youth justice strategy should identify actions that will prevent Aboriginal children and young people entering the Tasmanian youth justice system, enable early intervention for Aboriginal families whose children are engaging in antisocial behaviour, and divert those children and young people who are already in contact with police away from the youth justice system and, in particular, from detention. This should include:

- strategies to increase the use of cautions for Aboriginal children and young people
- the development of more pre-court diversion programs for Aboriginal children and young people, delivered by Aboriginal organisations

- strategies to minimise the number of Aboriginal children on remand through culturally safe supported bail accommodation and other bail assistance programs
- support for Aboriginal children and young people on community-based orders, aimed at helping them comply with the conditions of their orders and avoid escalation into custodial sentences.

In Chapter 9, we recommend an expanded role for ‘recognised Aboriginal organisations’ in child safety decision making under the Children, Young Persons and Their Families Act. In particular, we recommend that the Tasmanian Government partners with Aboriginal communities to develop models for transferring child safety decision-making authority for Aboriginal children to recognised Aboriginal organisations, and create a statutory framework to facilitate such transfer (Recommendation 9.15).

To enable this to occur, we recommend in Chapter 9 that:

- the new Executive Director for Aboriginal Children and Young People in the Department for Education, Children and Young People promotes and facilitates the establishment of recognised Aboriginal organisations (Recommendation 9.7)
- the Tasmanian Government invests in capacity building to ensure recognised Aboriginal organisations are fully resourced and their workforces fully equipped and supported to participate in child safety and out of home care decision-making processes for Aboriginal children, and to manage any transfer of decision-making authority (Recommendation 9.15).

Recognised Aboriginal organisations also have a role under the Youth Justice Act, namely to administer formal cautions to Aboriginal children or young people where requested by authorised police officers (we discuss cautions in Section 5).<sup>1009</sup> However, as noted in Chapter 9, the Tasmanian Government does not appear to have declared any organisations to be ‘recognised Aboriginal organisations’ for the purposes of the Children, Young Persons and Their Families Act (or, consequently, the Youth Justice Act). In that chapter, we recommend that the Tasmanian Government partners with Aboriginal communities to promote and support the establishment of recognised Aboriginal organisations.

We consider there could be a broader role for recognised Aboriginal organisations in youth justice processes in respect of Aboriginal children and young people. This could include delivering local diversionary programs for Aboriginal children and young people, leading conferencing under the Youth Justice Act, and designing and administering community-based youth justice options, including alternatives to custody for Aboriginal children and young people. These options should be examined under the auspices of the proposed Aboriginal youth justice strategy.

## Recommendation 12.27

1. The Tasmanian Government, to protect Aboriginal children and young people against the risk of sexual abuse in youth detention, should urgently develop, in partnership with Aboriginal communities, an Aboriginal youth justice strategy that is underpinned by self-determination and that focuses on prevention, early intervention and diversion strategies for Aboriginal children and young people. Aboriginal communities should be funded to participate in developing the strategy.
2. The strategy should consider and address, among other matters:
  - a. legislative reform to enable recognised Aboriginal organisations to design, administer and supervise elements of the youth justice system for Aboriginal children and young people
  - b. capacity building and funding for recognised Aboriginal organisations to participate in youth justice decision making in relation to Aboriginal children and young people, and to deliver youth justice services to Aboriginal children and young people
  - c. the use of police discretion in the investigation and processing of Aboriginal children and young people, including cautioning, arrest, custody, charging and bail
  - d. alternative pre-court diversionary options for Aboriginal children and young people
  - e. mechanisms to increase the likelihood of Aboriginal children and young people receiving bail and minimise the number of Aboriginal children and young people on remand, including culturally responsive supported bail accommodation and other bail assistance programs, and legislative reform to require bail decision makers to consider a child's Aboriginal status
  - f. mechanisms to support Aboriginal children and young people to comply with the conditions of community-based youth justice orders, to minimise their likelihood of breaching conditions and entering detention.

## 7.2 Design of new youth justice facilities

As outlined in Section 2, the Government intends to replace Ashley Youth Detention Centre with a ‘detention/remand centre’, two assisted bail facilities and two supported residential facilities for children and young people leaving detention on a supervised release order (among other pathways in).<sup>1010</sup> The supporting documentation for these facilities does not indicate how they will meet the specific needs of Aboriginal children and young people.

Participants in our consultations with Aboriginal communities told us that, as a general principle, there should be institutions specifically for Aboriginal children, run by Aboriginal communities:

We need our own Aboriginal people involved with a system to handle our Aboriginal children. Or at least have some Aboriginal Elders on these groups who can have some input. Trained professionals that have a cultural understanding and not just a textbook understanding—we need those people to guide and make and create those places.<sup>1011</sup>

One participant suggested establishing an alternative to Ashley Youth Detention Centre where children and young people are guided by Elders in a homelike environment:

... where children are treated with respect, and treat us with respect ... they need to be with their people ... in a place where they are safe mentally and emotionally.<sup>1012</sup>

Another participant referred to a system where Aboriginal children and young people are ‘sent to “healing” places for Aboriginal people rather than jail’.<sup>1013</sup> Other participants highlighted the need for an alternative to Ashley Youth Detention Centre, where Aboriginal children and young people can be ‘reconnected with their culture’.<sup>1014</sup>

Some participants referred to an earlier program for Aboriginal children and young people that was run by the Tasmanian Aboriginal Centre on Lungtalanana/Clarke Island in Bass Strait.<sup>1015</sup> There were mixed views among Aboriginal community members about this program. Heather Sculthorpe, Chief Executive Officer, Tasmanian Aboriginal Centre, told us that there were challenges in managing this program:

... we got funding so that kids didn’t have to go to Ashley, kids didn’t have to get sent away. In the end the State defunded that because not enough kids were using it, and we tried to say, well, we can’t just put people on that island to look after kids. When Ashley decides to let a kid leave, we can’t just find people then, we have to have them all the time and equipped to look after the children who are there. There’s also some difficulty in young people not wanting to be isolated there and wanting to spend time with their mates, so it was not well attended but it was certainly not well funded: I think it got \$140,000 a year.<sup>1016</sup>

In 2007, a Select Committee of the Tasmanian Parliament recommended that the Government assess the 'efficiency and benefits of alternate strategies such as the diversion of Aboriginal youth to Clarke Island-based programs'.<sup>1017</sup> In its response to the Select Committee's report, the Government noted that retaining and developing programs such as those on Clarke Island was 'extremely important'.<sup>1018</sup>

Ms Sculthorpe indicated that after the Clarke Island program ended, the Tasmanian Government began sending Aboriginal children to the Many Colours One Direction program in the Northern Territory, which was highly problematic.<sup>1019</sup> That program is discussed in Chapter 9.

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Victoria's youth justice centres were harmful, often unsafe environments for Aboriginal children and young people.<sup>1020</sup> It examined best practice youth justice facilities internationally and concluded that small, homelike residences could:

- reduce young people's stress, improve their behaviour and increase the likelihood that they will engage in rehabilitation
- allow staff to build relational security rather than relying on physical restraints, resulting in fewer adverse incidents
- provide the opportunity to place children and young people closer to their families
- enable flexibility for community members to be part of the daily life of the residence
- give children and young people more opportunities to build social skills and connections that could improve their chances of successfully returning to the community.<sup>1021</sup>

The Victorian Commission for Children and Young People recommended that, as a step towards having no Aboriginal child or young person in custody, the Victorian Government should work with Aboriginal communities to establish three small, homelike facilities for Aboriginal children and young people serving custodial sentences.<sup>1022</sup> The recommended facilities should each have no more than six beds and allow for Aboriginal children and young people to connect with their culture and community.<sup>1023</sup>

The facilities would need to provide therapeutic, trauma-informed care, including mental health support and drug and alcohol treatment, as well as access to education.<sup>1024</sup> They should also employ Aboriginal staff who are trained to resolve conflict through restorative justice approaches.<sup>1025</sup>

The Victorian Commission for Children and Young People indicated that, while there should be Aboriginal community involvement in setting up and managing these facilities—possibly via a ‘joint government and community management model’—it was not aware of an Aboriginal community or Aboriginal organisation in Victoria that wanted to fully manage a closed facility for sentenced Aboriginal children and young people.<sup>1026</sup>

The Victorian Commission for Children and Young People separately recommended establishing two small, homelike, non-secure facilities to provide therapeutic and culturally appropriate care for Aboriginal children and young people with highly complex needs who were likely to be refused bail based on their high risk of further offending.<sup>1027</sup> These facilities would be based on the Oranga Tamariki remand homes in New Zealand.<sup>1028</sup>

In Chapter 9, we recommend that the Tasmanian Government works with Aboriginal communities to establish fully resourced, Aboriginal-led, therapeutic residential programs for Aboriginal children who have been removed from their families under the Children, Young Persons and Their Families Act, and for whom an appropriate placement with an Aboriginal carer cannot be found (Recommendation 9.15). Such residential programs should be separate from any facilities designed for Aboriginal children who are on remand or serving a custodial sentence.

We acknowledge that creating residential facilities specifically for Aboriginal children and young people in the youth justice system may be impractical in a jurisdiction such as Tasmania, where the custodial sentenced and remand populations are small. There is a risk that Aboriginal children and young people would feel ‘siloes’ in such facilities. We also note that it may not be appropriate for an Aboriginal organisation to manage a secure facility for sentenced Aboriginal children and young people in Tasmania. These issues require more consideration, in partnership with Aboriginal communities.

Regardless of whether a detention or remand facility specifically for Aboriginal children and young people is established, it is important to ensure any new facilities are culturally safe and designed to meet the specific needs of Aboriginal children and young people.

Cultural safety (discussed in Section 7.3) is affected by the physical design of custodial facilities—well-designed indoor and outdoor cultural spaces can ‘provide opportunities for education, reflection, sharing stories and mentoring’ and promote strong connection to culture for Aboriginal children and young people.<sup>1029</sup> Such connection is essential for the wellbeing of Aboriginal children and young people and is a protective factor against child sexual abuse.

Poorly designed spaces can have the opposite effect. An Aboriginal Elder told us that when she visited Ashley Youth Detention Centre, she was not given a culturally appropriate space (for example, outdoors) to spend time with Aboriginal young people, describing the environment as ‘too institutionalised’.<sup>1030</sup>



Cultural safety for Aboriginal children and young people in detention also requires:

- the availability of cultural programs delivered by Aboriginal organisations
- regular and consistent access to family and community members
- the presence and support of Aboriginal staff.

These issues are discussed in more detail in Section 7.3.

The Tasmanian Aboriginal Legal Service has recommended that:

Tasmania’s Aboriginal communities be included as co-designers of facilities, infrastructure, programs and intended outcomes for replacement(s) for the Ashley Youth Detention Centre in order to ensure that facilities are culturally safe for Aboriginal children and young people as well as trauma- and sexual-abuse-informed and sensitive to other specific needs including disability and drug and alcohol problems.<sup>1031</sup>

We agree, and recommend that these issues be examined in the context of the Aboriginal youth justice strategy recommended in Section 7.1.

## Recommendation 12.28

The Tasmanian Government should ensure:

- a. any new facilities intended to replace Ashley Youth Detention Centre are co-designed with Aboriginal communities and include culturally enriching environments for Aboriginal children and young people that promote connection to family, community and Country
- b. the Aboriginal youth justice strategy (Recommendation 12.27) considers whether a small, homelike facility that has Aboriginal staff, provides trauma-informed care and enables Aboriginal children and young people to connect with culture through the involvement of local Aboriginal communities, should be established specifically for Aboriginal children and young people who are remanded or serving a custodial sentence. Careful consideration should be given to the most appropriate management model for such a facility.

## 7.3 Cultural safety in youth detention

According to SNAICC – National Voice for our Children, and the Victorian Aboriginal Child Care Agency, ‘cultural safety’ is:

... the positive recognition and celebration of cultures. It is more than just the absence of racism or discrimination and more than ‘cultural awareness’ and ‘cultural sensitivity’. It empowers people and enables them to contribute and feel safe to be themselves.<sup>1032</sup>

A culturally safe environment for Aboriginal children and young people is one where they are supported to connect with their culture and develop their identity.<sup>1033</sup> As one participant in our consultations said:

Culture is the way to come out of it. That's what makes me feel safe. I believe that culture is the answer.<sup>1034</sup>

The *Take Notice, Believe Us and Act!* report we commissioned found that most Aboriginal children and young people interviewed for the report did not know what cultural safety was, which suggests that it is not embedded in the organisations with which they interact.<sup>1035</sup> That report concluded:

Organisations need to foster environments that promote cultural safety and recognise the ways that culture and connection can be protective and act to empower children and young people from Aboriginal and culturally and linguistically diverse backgrounds.<sup>1036</sup>

As noted in Chapter 9, for Aboriginal children and young people, connection to culture through family and community can increase protective factors against the risk of sexual abuse by helping to develop identity and a sense of belonging and by fostering high self-esteem, emotional strength and resilience.<sup>1037</sup>

Conversely, Aboriginal children and young people who are disconnected from their family, community and culture are 'at great risk of psychological, health, developmental and educational disadvantage' and 'suffer as children and later as adults from the grief and loneliness of not belonging'.<sup>1038</sup> This includes Aboriginal children who are disconnected from their families, communities and culture when they are remanded or sentenced to detention.

It is therefore essential that Tasmania's youth detention facilities support Aboriginal children and young people to maintain or build connections to family, community and culture while they are detained. For Aboriginal children and young people in youth detention who have previously been removed from their immediate families by the child protection system, connection to extended family, kin and Aboriginal community members is vital.

### 7.3.1 Identifying Aboriginality

For youth detention facilities to be culturally safe for Aboriginal children and young people, staff must accurately identify the Aboriginal status of those in detention.

As discussed in Chapter 9, in almost every meeting we had with Aboriginal communities, participants raised concerns about how Aboriginal status is determined in Tasmania and who is responsible for determining it. Ms Sculthorpe of the Tasmanian Aboriginal Centre also raised these issues in her evidence.<sup>1039</sup> In Chapter 9, we note that it is beyond the scope of our Inquiry to make recommendations on these questions.

However, it is within our terms of reference to address the increased risk of sexual abuse that Aboriginal children and young people face in youth detention due to their over-representation in the youth justice system. To provide adequate protection and support to Aboriginal children and young people in detention in relation to the risk of sexual abuse, it is important to ensure the Aboriginal status of children and young people in detention is accurately identified and recognised, so all Aboriginal children and young people in detention can be supported to stay connected to family, community and culture.

The Department's written procedure for admitting a child or young person into detention states that if the person is known to Community Youth Justice, their Aboriginal status must be collected from the Youth Justice Information System, and this information must be added to the 'Admissions Checklist'.<sup>1040</sup> The former Department of Health and Human Services had a department-wide procedure that required all staff of Children and Youth Services to determine a client's Aboriginal status every time the client 'commence[d] an involvement with' Children and Youth Services.<sup>1041</sup> This procedure continues to apply to children and young people being admitted to youth detention.<sup>1042</sup>

Secretary Pervan told us that the 'admission and induction process ask[s] direct questions concerning [A]boriginality'.<sup>1043</sup> He also told us that Aboriginal status is recorded at Ashley Youth Detention Centre through self-identification and 'may be updated throughout a young person's involvement with Youth Justice, which results in data that is changeable over time'.<sup>1044</sup>

The Commissioner for Children and Young People has previously observed about the out of home care system that children's Aboriginal status is not always consistently identified or recorded.<sup>1045</sup> Secretary Pervan told us that the former Department of Communities was 'improving collection and completion of Aboriginal status for children at the Advice and Referral Line and Child Safety Service'.<sup>1046</sup>

Nevertheless, we recommend in Chapter 9 that the Tasmanian Government ensures the Aboriginal status of all Aboriginal children in contact with Child Safety Services is accurately identified and recorded at the earliest opportunity (Recommendation 9.15). We anticipate that this would also result in better identifying Aboriginal status for children and young people entering youth detention.

Secretary Pervan told us that the induction assessment at Ashley Youth Detention Centre identifies a young person's:

... background, physical and mental health, literacy, drug use, disability, indigenous status, familial and personal relationships and the young person's identified gender and sexuality (as identified by them). The assessment then allows for meaningful supports to be put into place that address their specific needs, and that they are stable and informed about their rights and routine before moving into a unit with other young people.<sup>1047</sup>

He also said that ‘connection with community [E]lders’ is sought for Aboriginal children and young people.<sup>1048</sup>

Where a child identifies as Aboriginal, the custodial case management guidelines require admissions staff to contact the Tasmanian Aboriginal Centre within 12 hours of the child’s admission into detention.<sup>1049</sup> However, the guidelines do not specify what role the Tasmanian Aboriginal Centre is to perform in respect of case management for the child, nor do they contemplate the possibility of the child wanting to be supported by an Aboriginal organisation other than the Tasmanian Aboriginal Centre.

We understand that, in some cases, a worker from the Tasmanian Aboriginal Centre has been involved in case management meetings, conferencing and exit planning for Aboriginal children and young people at Ashley Youth Detention Centre, but we did not receive detailed evidence on this.<sup>1050</sup>

The admission procedure and custodial case management guidelines should be updated to require custodial staff to:

- ask children and young people who identify as Aboriginal whether they would like the support of an Aboriginal organisation (whether a recognised Aboriginal organisation or otherwise) or an Aboriginal community member while they are detained
- notify the relevant organisation or individual within 12 hours of the child or young person’s admission
- facilitate the involvement of the child or young person’s nominated representative in case planning, case management and exit planning in respect of the child or young person.

### 7.3.2 Cultural support and programs

Several of the children and young people interviewed for the *Take Notice, Believe Us and Act!* report indicated that they were Aboriginal, but none identified ways in which organisations were taking steps to ensure their cultural safety.<sup>1051</sup>

Victim-survivor Charlotte (a pseudonym), who is Aboriginal and was detained in the 2000s, told us she did not receive any cultural support when she was in Ashley Youth Detention Centre (refer to Chapter 11, Case study 1).<sup>1052</sup> Participants in our consultations with Aboriginal communities told us that the cultural needs of Aboriginal children and young people in Ashley Youth Detention Centre were not being met.<sup>1053</sup> One community member said:

All the kids in jail are lost. They have lost their culture and community, and there is nothing for them to connect with when they are feeling low.<sup>1054</sup>

During our visit to Ashley Youth Detention Centre in August 2021 (discussed in Chapter 2), we observed only a few small signs or symbols to celebrate or recognise Aboriginal culture compared with the youth detention facilities we visited interstate, which had large, landscaped cultural outdoor areas and Aboriginal artwork and posters.

The Department provided us with a copy of its *Guidelines for Working with Young Aboriginal People and Other Young People from Culturally and Linguistically Diverse (CALD) Backgrounds*, dated August 2010.<sup>1055</sup> According to this document:

- case management staff will ‘take responsibility for including any cultural needs in a young person’s case plan and ensure that appropriate programs/practices are implemented and monitored’
- case management staff will ‘seek and pay particular notice of cultural advice from family and the cultural community of the young person’
- a young person’s cultural needs will be clearly conveyed to the unit staff responsible for day-to-day management and relayed to staff if the young person is transferred to another unit.<sup>1056</sup>

However, beyond a requirement to notify the Tasmanian Aboriginal Centre of the child’s admission to custody, this document does not include any detail on how to meet the cultural needs of Aboriginal children in detention.<sup>1057</sup> In particular, it does not require staff to determine whether an Aboriginal child or young person already has a cultural support plan, nor does it provide any guidance on how to identify the cultural support needs of an Aboriginal child in detention.

Also, by including children and young people from culturally and linguistically diverse backgrounds and referring broadly to ‘cultural needs’, these guidelines fail to acknowledge or identify the unique experiences and needs of Aboriginal children and young people in detention.

Counsel Assisting our Inquiry asked Secretary Pervan to describe the extent to which there were programs at Ashley Youth Detention Centre to meet the needs of Aboriginal children and young people.<sup>1058</sup> In response, Secretary Pervan said:

My understanding is that it actually depends on the child and which particular community they are from. The involvement and engagement of some community-controlled organisations is at a higher level and more direct, particularly for some young people; with others it’s less so; it depends on the engagement and capability of the community organisation that’s most representative of the young people in Ashley. It’s something that we have invited, it’s something that we’re very keen to increase, and is part of our commitment through the Closing the Gap national agreements.<sup>1059</sup>

Secretary Pervan did not offer any more detail on the cultural support provided to Aboriginal children and young people in detention—for example, on specific cultural

programs that are being or have been run. We also note that the Custodial Inspector's 2019 *Equal Opportunity Inspection Report* on Ashley Youth Detention Centre failed to discuss this issue in any detail, finding that 'for the most part, young people at [Ashley Youth Detention Centre] are treated fairly and equitably'.<sup>1060</sup>

Dr Michael Guerzoni, Indigenous Fellow—Academic Development, University of Tasmania, told us that it is important for Aboriginal children and young people in detention to receive cultural immersion and cultural support, and for 'their Indigeneity [to be] encouraged and supported'.<sup>1061</sup>

Participants in our consultations with Aboriginal communities also told us that connection with culture for Aboriginal children and young people in detention is essential.<sup>1062</sup> Several Elders indicated that they used to visit Aboriginal children and young people in Ashley Youth Detention Centre as part of various programs, with one commenting:

I loved seeing the kids at Ashleys. They could just be themselves, have a yarn. Your heart broke when you left.<sup>1063</sup>

The Department did not provide us with any information about these programs, although it did provide a copy of a 2021 Ashley Youth Detention Centre newsletter that refers to '[c]ultural story sharing with ... an Aboriginal Elder', which would 'lead to the design of a yarning circle [and] bush tucker garden to be developed in the outdoor area'.<sup>1064</sup>

Cultural programs such as visiting Elders programs are an important way to support cultural connection for Aboriginal children and young people in detention. In our consultations with Aboriginal communities, we also heard that on-Country programs can help Aboriginal children and young people 'feel proud of themselves, release emotions and learn about themselves'.<sup>1065</sup> However, participants also referred to the absence of cultural programs, such as men's or women's 'sheds' in some areas, noting that some earlier programs had been discontinued.<sup>1066</sup>

Connection to culture for Aboriginal children and young people in detention could also be facilitated through a mentoring program. The Victorian Commission for Children and Young People has highlighted the benefits of cultural mentors for Aboriginal children and young people who are in contact with the youth justice system, particularly where programs use mentors with lived experience of the youth justice system, who can be 'credible messengers' in providing support to Aboriginal children and young people.<sup>1067</sup> Mentoring programs for children and young people in contact with the youth justice system have also been shown to reduce offending behaviour.<sup>1068</sup>

The Tasmanian Aboriginal Legal Service has referred to the potentially 'huge impact' of positive role models with lived experience of the youth justice system acting as mentors for Aboriginal children and young people in contact with the system.<sup>1069</sup>

Participants at one of our consultations with Aboriginal community members referred to the positive contributions of an Aboriginal worker based in an Aboriginal organisation who has lived experience of the youth justice system and has developed a strong rapport with Aboriginal children and young people in detention.<sup>1070</sup> Madeleine Gardiner, former Manager, Professional Services and Policy at Ashley Youth Detention Centre, also referred to this ‘respected Aboriginal mentor’ who performs positive work in Ashley Youth Detention Centre.<sup>1071</sup>

### 7.3.3 Visits, temporary leave and phone calls

Visits, temporary leave and phone calls are also important means of enabling Aboriginal children and young people in detention to stay connected to family, community and culture.

As discussed in Section 6.7, children and young people at Ashley Youth Detention Centre:

- have the right to regular contact with family members through personal visits, but management can refuse a visit if it believes that the ‘security, safety or good order of the Centre or the health or well-being of the young person may be adversely affected by allowing the visit’<sup>1072</sup>
- can apply for temporary leave from the Centre—applications must undergo a thorough risk assessment, including consideration of the young person’s ‘behaviour and attitude at or near the time of the proposed leave’, any history of threats or attempts to abscond, and the young person’s ‘recent and current colour status’ under the Behaviour Development Program<sup>1073</sup>
- can make seven phone calls each week and are entitled to extra calls if they achieve ‘yellow’ or ‘green’ status in the Behaviour Development Program.<sup>1074</sup>

Ms Gardiner described two occasions where Aboriginal young people were denied visitation rights in circumstances where the visits were therapeutically important for these young people.<sup>1075</sup> The first occasion involved an Aboriginal young person being refused a visit from his brother in 2018, with no valid rationale apparent to Ms Gardiner.<sup>1076</sup> Ms Gardiner successfully appealed this decision.<sup>1077</sup>

In the second case, in 2019, Ms Gardiner’s team had organised for a mentor from an Aboriginal organisation to visit Ashley Youth Detention Centre and sit with an Aboriginal young person while he viewed video footage from his father’s funeral, which he had earlier been denied permission to attend.<sup>1078</sup> Although the mentor’s visit was initially approved, Ms Gardiner later discovered that it had been cancelled by Ashley Youth Detention Centre management, without consultation, on the day it was scheduled to occur.<sup>1079</sup> The reason provided to Ms Gardiner for the cancellation was that there were not enough staff to supervise the visit.<sup>1080</sup> She described these decisions as ‘not child-focused’ and ‘very insensitive’.<sup>1081</sup>



Were these situations to occur in future, we hope they would be approached with awareness of and sensitivity to the cultural needs of Aboriginal children and young people in detention on the part of Ashley Youth Detention Centre management and staff. Attendance at funerals can be an important way to maintain family connection and fulfil cultural obligations.<sup>1082</sup> Where this is not possible, every effort must be made to enable Aboriginal children and young people to take part in important cultural rituals in alternative ways.

We are also concerned that custodial policies allow the denial of an application for temporary leave to attend a family funeral based on a child or young person's recent behaviour and status in the Behaviour Development Program. The behaviour of a child or young person whose family member has recently died may be exacerbated by grief and trauma, and this should not be a reason to deny them access to their family.

We did not hear any evidence specifically about the ability of Aboriginal children and young people to make or receive phone calls from Ashley Youth Detention Centre. However, we consider that it is problematic to link a child's right to contact their family or community with the child's behaviour.

In Section 6.7.5, we recommend that the Department:

- develops and implements a policy on the importance to children and young people in detention of maintaining or building connections with their family and community that specifies ways to promote such connections and clearly states that entitlements to visits, temporary leave and phone or video calls cannot be denied on the basis of a child or young person's behaviour
- provides reasonable assistance (including financial help) to members of a child or young person's family or Aboriginal community to enable them to visit the child or young person frequently in detention (Recommendation 12.23).

### 7.3.4 Recruitment of Aboriginal staff

As noted, the National Royal Commission recommended that governments consider strategies for recruiting and developing Aboriginal staff to work at all levels of the youth justice system.<sup>1083</sup> Despite the substantial over-representation of Aboriginal children and young people in youth detention in Tasmania, the staffing structure for Ashley Youth Detention Centre provided to us by Secretary Pervan does not include any role(s) dedicated specifically to the wellbeing of Aboriginal children and young people in detention, such as an Aboriginal liaison officer.<sup>1084</sup>

Victim-survivor Charlotte (a pseudonym) told us that there was no one in Ashley Youth Detention Centre in the 2000s who helped her to feel culturally safe.<sup>1085</sup> She said that it would have made a difference while she was in the Centre if she had been supported by an Aboriginal worker to whom she could have disclosed the abuse she had experienced:

There was none at that stage for anyone that was Aboriginal. I've been to [adult] jails in the past, like after that, and the Aboriginal support, like, the support workers that help, they do so much for people. Like, they need more of it and they definitely needed someone like that in [Ashley Youth Detention Centre], like, that you could go to tell stuff like that.<sup>1086</sup>

In its 2021 *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Aboriginal liaison officers in Victoria's youth justice centres played an important role in supporting the cultural needs of Aboriginal children and young people in detention by contributing to the work of care teams, making sure Aboriginal children's voices are heard in decision making about them and generally supporting them.<sup>1087</sup> The *Our Youth, Our Way* report quotes the lead consultant forensic psychiatrist for Victoria's youth justice centres on the positive contribution that Aboriginal liaison officers make to therapeutic treatment for Aboriginal children and young people:

Having [Aboriginal liaison officers] there completely changes the therapeutic results. The Aboriginal clients suddenly open up and the [Aboriginal liaison officers] do a ton of work explaining to the young person how it's going to work and that it's just a chat. If I was designing the perfect service, we would have one-on-one support for every Aboriginal young person.<sup>1088</sup>

However, the Victorian Commission for Children and Young People also found that, despite the value placed in Aboriginal liaison officers by the youth justice system, these roles were overloaded and experienced high turnover.<sup>1089</sup> It recommended that the Victorian Department of Justice and Community Safety review the Aboriginal liaison officer program to assess how it could best meet the competing needs and demands placed on it.<sup>1090</sup>

Participants in our consultations with Aboriginal communities similarly told us that Aboriginal liaison officers in schools were overloaded and not adequately resourced, and that more training and support was needed for people to take on these and similar roles.<sup>1091</sup>

We consider that there would be considerable benefit in establishing an Aboriginal liaison officer role or roles in Ashley Youth Detention Centre and any replacement detention facilities. The primary function of the Aboriginal liaison officer should be to support Aboriginal children and young people in detention. This should include involvement in case management and exit planning, and facilitating cultural support for Aboriginal children and young people. Aboriginal liaison officers should be identified positions.

In establishing these roles, the Tasmanian Government should ensure appointees are not overloaded and that they receive professional development, including training, in working with children and young people who have experienced trauma.

In Chapter 9 and Section 11.4 of this chapter, we recommend establishing an independent community visitor scheme for children and young people in out of home care and youth detention (Recommendations 9.34 and 12.36). This scheme would involve independent community visitors appointed by the new Commission for Children and Young People (Recommendation 18.6) undertaking weekly (or more frequent) visits to children and young people in detention, building trusting relationships with them, listening to any of their concerns about their treatment in detention and advocating on their behalf (this is discussed in Section 11.4). We recommend that, wherever possible, Aboriginal children and young people have access to an Aboriginal independent community visitor (Recommendation 12.36).

While Aboriginal liaison officers and independent community visitors would each be responsible for developing trusting relationships with Aboriginal children and young people in detention, we consider that their functions are different and that there is an important role for both. Aboriginal liaison officers would be employed by the Department and would be involved with Aboriginal children and young people on a day-to-day basis, providing them with cultural and other support. In contrast, independent community visitors would offer an external oversight mechanism for the safety and wellbeing of Aboriginal children and young people in detention and, where needed, advocate on their behalf to help to resolve their concerns.

### **7.3.5 Professional development for custodial staff**

As noted, the National Royal Commission pointed to the need for culturally competent staff in custodial facilities who understand the needs and experiences of Aboriginal children in detention.<sup>1092</sup>

The Ashley Youth Detention Centre Learning and Development Framework (discussed in Section 4.7.1) indicates that staff undergo mandatory ‘Aboriginal Cultural Awareness’ training, and that ‘[c]ultural awareness will be embedded in all learning and development opportunities’.<sup>1093</sup> The evidence we heard (detailed in this section) indicates this training has not resulted in a culturally safe environment that responds to the specific experiences and needs of Aboriginal children and young people.

As discussed in Section 6.3, staff in detention facilities need to be equipped with the skills to undertake trauma-informed, evidence-based interventions with all children and young people in detention—many of whom have experienced significant trauma and may be engaging in challenging behaviours—without resorting to the use of force or isolation. However, to provide such interventions for Aboriginal children and young people, custodial staff also need to understand the nature and impacts of intergenerational trauma experienced by Aboriginal communities; the effects of dislocation from family, community and Country on Aboriginal children’s wellbeing; and the need for Aboriginal children to be connected to culture while in detention.<sup>1094</sup> The training Ashley Youth Detention Centre staff receive does not appear to be equipping them with this knowledge or these skills.

Research indicates that, nationally, Aboriginal young people aged between 15 and 24 years are more than five times more likely to self-harm than non-Aboriginal young people and that the risk of self-harm is compounded for Aboriginal children and young people in detention, where there is also a high prevalence of self-harming behaviour.<sup>1095</sup>

The Ashley Youth Detention Centre *Suicide and Self-Harm Prevention Procedure* has only one reference to Aboriginal children and young people.<sup>1096</sup> This occurs in the context of discussion about the ongoing therapeutic management of a child or young person who has been the subject of a ‘suicide and self-harm notification’.<sup>1097</sup> The procedure states that the ‘risk intervention team’ must discuss and agree on the type and level of interaction that the young person should have with parents, residents, staff members and other support people, noting that ‘increased access to family may be an important protective factor’ for Aboriginal children and young people.<sup>1098</sup>

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Aboriginal children and young people were substantially over-represented in incidents involving attempted suicide and self-harm in Victoria’s youth justice centres, possibly indicating that Aboriginal children and young people were experiencing high levels of distress at being incarcerated.<sup>1099</sup> The Commission for Children and Young People recommended that the Victorian Department of Justice and Community Safety develop a strategy to provide consistent and therapeutic responses to children and young people at risk of suicide or self-harm in detention, including specific elements to ensure a culturally safe response to Aboriginal children and young people.<sup>1100</sup>

The Draft Youth Justice Blueprint refers to the need for the youth justice workforce to be:

... culturally competent so it can support and respond to the needs of Aboriginal children and young people in the youth justice system and work with Aboriginal communities across the continuum to help them support their children and young people.<sup>1101</sup>

Also, as outlined in Section 6.3.3, the Keeping Kids Safe Plan states that the Australian Childhood Foundation Centre for Excellence in Therapeutic Care started a review of the Learning and Development Framework in September 2022.<sup>1102</sup> This review was due to be completed by 31 January 2023.<sup>1103</sup> In June 2023, the Department advised that the review was progressing and was anticipated to be completed by 30 June 2023.<sup>1104</sup> We have not been provided with the review’s findings or recommendations.

In updating the Learning and Development Framework, the Tasmanian Government should ensure the framework is designed to equip staff with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including responding in trauma-informed and culturally safe ways to Aboriginal children and young people who are engaging in self-harm or other challenging behaviours.

## Recommendation 12.29

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

- a. updating admission procedures and case management guidelines to require staff to
  - i. ask children and young people who identify as Aboriginal whether they would like the support of an Aboriginal organisation or an Aboriginal community member while they are detained
  - ii. notify the nominated organisation or individual within 12 hours of the child or young person's admission
  - iii. facilitate the involvement of the child or young person's nominated representative in case planning, case management and exit planning in respect of the child or young person
- b. updating relevant guidelines and procedures to require staff to consult with an Aboriginal child or young person's community to determine how best to provide individual cultural support to the child or young person while they are in detention
- c. working with Aboriginal communities to establish ongoing cultural programs for Aboriginal children and young people in detention, such as visiting Elders programs, on-Country programs and cultural mentoring programs
- d. ensuring the new policy on supporting children and young people in detention to maintain connections to their families and communities (Recommendation 12.23) emphasises the central importance of connection to family, community and culture for the wellbeing of Aboriginal children and young people in detention
- e. establishing the role of Aboriginal liaison officer in youth detention to support Aboriginal children and young people, including by facilitating cultural support and becoming involved in case planning, case management and exit planning
- f. ensuring the updated Ashley Youth Detention Centre Learning and Development Framework is designed to equip staff with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including providing trauma-informed and culturally safe responses to children and young people engaging in self-harm or other challenging behaviours.

## 7.4 Support for Aboriginal children leaving detention

As discussed in Section 6.8, we heard about a lack of effective support for children and young people leaving detention ('throughcare support') in Tasmania.<sup>1105</sup> Many participants in our consultations with Aboriginal communities commented on the absence of support for Aboriginal children and young people who are released from Ashley Youth Detention Centre.<sup>1106</sup> Some referred to the lack of safe and stable homes for Aboriginal children to return to:

I remember one kid who couldn't go home afterwards because his dad and pop were on the drugs. There was nothing you could do.<sup>1107</sup>

Many participants commented that the absence of throughcare support for Aboriginal children and young people created a high risk that they would engage in further offending and return to detention:

When our kids are in Ashleys, they've got nowhere to go, nothing to do, no follow up ... that's a really big problem. They reoffend and go back in there again.<sup>1108</sup>

Another participant said:

If they come out and go back to the same community, then what happens? They just go back to where they were before, and then end up back in Ashleys.<sup>1109</sup>

One Aboriginal community member suggested that, for some Aboriginal children and young people, the relative stability provided by Ashley Youth Detention Centre was preferable to their circumstances following release:

... some kids would get themselves in trouble so they could go back there, because they don't have anywhere else to go, they just go home to drugs and abuse ... for some of them it's a roof over their heads, it's meals three times a day.<sup>1110</sup>

These comments raise serious concerns about the Tasmanian youth justice system and related service systems, most notably the housing, child protection and out of home care systems. There is clearly an urgent need to address the lack of support for Aboriginal children and young people leaving detention in Tasmania.

Participants in our consultations with Aboriginal communities felt that support for Aboriginal children and young people following their release from youth detention should include housing, cultural support, drug and alcohol services and educational support.<sup>1111</sup>

As outlined in Section 6.8.2, the Draft Youth Justice Blueprint refers to the commencement of service planning at the earliest opportunity for a young person in contact with the youth justice system.<sup>1112</sup> This is welcome, but it is concerning that the Draft Youth Justice Blueprint does not refer to throughcare support specifically for Aboriginal children and young people, given the substantial over-representation of Aboriginal children and young people in detention.

We also welcome the Government's proposed supported residential facilities as temporary or transitional accommodation for children and young people released from detention (refer to Section 6.8.2). However, again, we note that the limited information provided about these facilities does not include any detail on how they will meet the particular needs of Aboriginal children and young people.<sup>1113</sup>

The North Australian Aboriginal Justice Agency provides a throughcare program for Aboriginal children and young people in youth detention in the Northern Territory.<sup>1114</sup> Case managers in this program support Aboriginal children and young people preparing to leave detention to 'help young people and their families develop strong and holistic post-release plans that address their goals, risks and transitional needs'.<sup>1115</sup> The program provides case management support following release for as long as the young person wants to remain involved, and there is an identified need.<sup>1116</sup>

The Victorian Aboriginal Child Care Agency manages the Youth Through Care program for Aboriginal children and young people aged 10 to 17 years in detention in Victoria. This program is funded by the National Indigenous Australians Agency.<sup>1117</sup> The program works to reduce reoffending by supporting Aboriginal children and young people through an 'intensive, holistic, client-centred, culturally appropriate and trauma-informed model with strong connection to family and Country'.<sup>1118</sup>

Youth Through Care program workers provide individual case management that starts from an Aboriginal child's or young person's entry into detention and continues for up to 24 months following their release.<sup>1119</sup> Post-release support can include helping children and young people attend Centrelink appointments, providing transport to and from drug and alcohol services, and visiting them in residential care or at home to provide social and emotional wellbeing support.<sup>1120</sup> Program workers may also provide outreach to the families of Aboriginal children and young people where the child or young person has not had recent contact with their family or if the worker has concerns about the welfare of a parent or carer of the child or young person.<sup>1121</sup>

We recognise the significant benefits of these programs but acknowledge that in a small jurisdiction such as Tasmania it may not be feasible to establish a separate throughcare support service for Aboriginal children and young people. In Section 6.8.3, we recommend that the Government establishes an integrated throughcare service for children and young people in detention that starts exit planning as soon as possible after a child or young person enters detention. This service should plan for safe and stable accommodation, access to physical and mental health support and help with education and employment after release to facilitate children and young people's reintegration into the community (Recommendation 12.24). This service must be culturally safe for Aboriginal children and young people, and responsive to their needs.



## 8 Harmful sexual behaviours in youth detention

Harmful sexual behaviours are highlighted as a concern in several chapters of our report. In Chapter 6 on education and Chapter 9 on out of home care, we explore the need for appropriate prevention and intervention responses for harmful sexual behaviours in those settings. In Chapter 21, we discuss the need for a statewide approach to therapeutic interventions for children who have engaged in harmful sexual behaviours.

As discussed in these other chapters, harmful sexual behaviours are generally considered to be:

... sexual behaviours displayed by children and young people that fall outside what may be considered developmentally, socially, and culturally expected, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force, or a misuse of power.<sup>1122</sup>

Harmful sexual behaviours are a known risk in youth detention and there must be measures in place to address this risk.<sup>1123</sup> In this section, we consider the significant improvements that must be made for Ashley Youth Detention Centre and any future detention facilities to better prevent and respond to harmful sexual behaviours among children and young people in these facilities.

We recommend that the Department develops a clear policy for preventing and responding to harmful sexual behaviours in youth detention. This policy must consider the full range of harmful sexual behaviours that may occur in those settings, so all children and young people involved can receive assistance. While we focus on youth detention in this section, the policy should also apply to other residential youth justice facilities such as the Government's proposed assisted bail facilities (discussed in Section 5.4) and supported residential facilities (discussed in Section 6.8).

### 8.1 National Royal Commission

The National Royal Commission found that harmful sexual behaviours can often occur as a result of trauma, which many children in youth detention have experienced.<sup>1124</sup>

The National Royal Commission also identified an increased risk of harmful sexual behaviours in youth detention, noting:

The risk of children sexually abusing other children may be high in youth detention because children who have harmful sexual behaviours or have engaged in criminal or antisocial behaviour are disproportionately clustered in youth detention institutions, and placement decisions involving highly complex children with serious backgrounds of offending are challenging for administrators. Many children with harmful sexual behaviours may also model their behaviour on how they see adults or older children behave in institutions.

Research also suggests that many children with harmful sexual behaviours act impulsively rather than in a premeditated manner. They may also be motivated by exerting power over or perpetrating violence towards other children.<sup>1125</sup>

The National Royal Commission made several recommendations relevant to harmful sexual behaviours in youth detention, including:

- Institutions need policies and procedures to understand, prevent and respond to harmful sexual behaviours.<sup>1126</sup>
- Children and young people should be assessed for risk for vulnerability to engaging in, or being subject to, harmful sexual behaviours before being placed in a detention centre. Placement decisions and supervision should be informed by these risk assessments to ensure the safest possible placements are provided for children.<sup>1127</sup>
- Children and young people who have displayed harmful sexual behaviours should have access to timely, expert assessment and a range of appropriate, coordinated interventions, including therapeutic interventions.<sup>1128</sup>
- Staff should receive training and ongoing professional development in trauma-informed care, including identifying and responding to harmful sexual behaviours and the needs of children and young people at risk of engaging in, or being subject to, harmful sexual behaviours.<sup>1129</sup>
- The facility should incorporate building and design features that reduce opportunities for harmful sexual behaviours to occur and monitor interactions between children and young people without infringing on children's privacy.<sup>1130</sup>
- Child-focused measures should exist to assist disclosure of harmful sexual behaviours such as children and young people having access to 'maximum contact' with trusted adults such as family, friends and community, and access to effective internal and external complaints-handling systems.<sup>1131</sup>

We discuss some of these issues—such as building design, increased access to trusted adults and effective complaints processes—in other sections of this chapter, as they relate to reducing the risk of all types of child sexual abuse in youth detention. In this section, we focus on recommendations specifically related to preventing and responding to harmful sexual behaviours in this setting.

We consider it useful to move beyond the National Royal Commission recommendations on risk assessments for harmful sexual behaviours to differentiate between screening assessments to accurately identify harmful sexual behaviours and clinical assessments for harmful sexual behaviours where risk is one component of the assessment. We elaborate on this approach in Section 8.4.2.

## 8.2 Harmful sexual behaviours at Ashley Youth Detention Centre

In her hearing evidence, the Director of Strategic Youth Services in the former Department of Communities acknowledged that Ashley Youth Detention Centre has had a longstanding problem with harmful sexual behaviours and has failed to address these behaviours through appropriate responses.<sup>1132</sup>

Since those hearings, the issue has remained a difficult one to address. In a submission to a parliamentary inquiry on adult imprisonment and youth detention, a staff member who worked at Ashley Youth Detention Centre between September and December 2022 stated that harmful sexual behaviours were commonplace and were directed at other young people as well as staff.<sup>1133</sup> The staff member described young people in the Centre as dismissing these incidents as ‘just playing, joking around’, with no complaints being made by the young people who experienced the behaviour.<sup>1134</sup>

In Chapter 11, Case study 2, we discuss several accounts of harmful sexual behaviours at Ashley Youth Detention Centre of which we were made aware. We identified systemic problems that contributed to the risk of harmful sexual behaviours among young people at the Centre, such as:

- a lack of assessment of the risk of harmful sexual behaviours for young people entering the Centre
- tensions between staff or teams within the Centre who held different views about how to manage the safety of young people
- staff lacking the knowledge to identify and respond appropriately to harmful sexual behaviours
- not always having a skilled investigative team available to the Centre when serious incidents occur.

Many of these problems are addressed by our recommendations in Section 8.5.

## 8.3 Clinical leadership

We consider that the therapeutic and wellbeing needs of the children and young people involved in harmful sexual behaviours are most likely to be given priority if professional staff with clinical expertise in harmful sexual behaviours are involved in assessing, monitoring and managing harmful sexual behaviours and in placement decisions.

This is a successful approach at Bimberi Youth Justice Centre in the Australian Capital Territory, where the Principal Practitioner, a clinical psychologist, oversees and is involved in decisions about risk, support needs and therapeutic interventions provided to children and young people at that centre.<sup>1135</sup>

Some progress has been made towards increasing clinical input at Ashley Youth Detention Centre. We heard that the Centre's Practice Manager had started meeting weekly, from 18 May 2022, with a Sexual Assault Support Service clinician to discuss any incidents or concerns about harmful sexual behaviours of children and young people in detention.<sup>1136</sup> The Practice Manager position has also been upgraded in pay classification in recognition of its specialised clinical role.<sup>1137</sup> The role includes 'clinical supervision' with operational staff to ensure they respond to disclosures of child sexual abuse in alignment with the advice provided by the Sexual Assault Support Service.<sup>1138</sup>

In its Keeping Kids Safe Plan, the Department stated that it had engaged a Senior Advisor from the Australian Childhood Foundation to provide a range of clinical review and support services for staff at Ashley Youth Detention Centre.<sup>1139</sup> We hope these services relate to harmful sexual behaviours as well as other risk and safety issues, and that this move precipitates a more cooperative relationship between those with clinical expertise and operational staff, as we recommend in Section 6.4.

To achieve greater clinical leadership on harmful sexual behaviours, staff in detention facilities and other residential youth justice facilities need to have ready access to harmful sexual behaviours specialists. In Chapter 9, we recommend establishing a Harmful Sexual Behaviours Support Unit in the new Office of the Chief Practitioner (refer to Recommendations 9.17 and 9.28).

The Harmful Sexual Behaviours Support Unit should support best practice responses in youth detention and other residential youth justice facilities through:

- tele-consults with staff at the facility to assist them in confirming the level of risk posed by behaviours and/or to assist the facility in developing a response plan for inappropriate or concerning sexual behaviours that can be addressed through a local area response without clinical intervention
- assistance in responding to critical incidents involving harmful sexual behaviours, including guidance on reporting, record keeping, clinical assessments and safety planning (including placement and supervision plans)
- support in accessing therapeutic treatment for children displaying harmful sexual behaviours, where this is clinically assessed as appropriate.

Given the unique characteristics of youth detention and the youth justice system, detailed youth justice-specific policies, protocols and practice guidance will be required.

The Harmful Sexual Behaviours Support Unit should support or lead development of these policies, protocols and guidance.

Allied health professionals working on site in youth detention and other residential youth justice facilities could support local clinical leadership in responding to harmful sexual behaviours. In Chapter 9, we recommend that more advanced professional development offerings be made available to relevant staff in the Child Safety Service, schools and youth justice (Recommendations 9.11 and 9.28).

## 8.4 Preventing harmful sexual behaviours

### 8.4.1 A proactive approach to sexual safety

Adolescence is a significant period in a child's sexual development. During puberty, adolescents are developing their sexual identity, which often involves consensual sexual exploration with peers. As noted, however, several factors increase the risk of inappropriate and harmful sexual behaviours in youth detention facilities.<sup>1140</sup> At the same time, children in detention are disproportionately likely to have experienced extensive school absenteeism or to have disengaged from education and are consequently less likely to have engaged in sexual health, respectful relationships and sexual safety education in schools.<sup>1141</sup>

These circumstances mean it is essential for youth detention to provide sex education tailored to the needs of a high-risk population. We heard that young people receive the 'Consent is a conversation' program through Ashley School, which promotes 'healthy, respectful intimate relationships'.<sup>1142</sup> We consider, however, that the National Royal Commission's observations indicate that sex education for children and young people in detention should go further. Similar to our recommendation for children and young people in out of home care (refer to Recommendation 9.28), sex education for children and young people in detention should be tailored to that setting and cover issues such as consent and what constitutes sexually abusive behaviours by adults and other children, as well as pornography and its impacts on children's views about relationships, sexuality and gender.<sup>1143</sup>

Further, we consider that a proactive approach for staff and young people in detention should form part of the Department's policy on harmful sexual behaviours in residential youth justice facilities.<sup>1144</sup> As discussed in our out of home care volume (Chapter 9), 'Power to Kids' is an example of a program designed for residential out of home care that could be adapted for use in detention and other residential youth justice facilities. Power to Kids is a multifaceted program proven to reduce the risk to children in residential care of sexual abuse in the form of harmful sexual behaviours, child sexual exploitation and dating violence.<sup>1145</sup> The Power to Kids model includes respectful relationships and sexuality education for the whole facility, including staff and young people, and guidance about responding appropriately to harmful sexual behaviours when they occur.<sup>1146</sup> Such strategies support a shared understanding of appropriate behaviours and a culture that reduces the likelihood that harmful sexual behaviours will occur.<sup>1147</sup>

### 8.4.2 Identification and assessment

The Government's Fifth Annual Progress Report and Action Plan on implementing the recommendations of the National Royal Commission ('Fifth Annual Report') describes 'new admission practices' whereby children and young people entering Ashley Youth Detention Centre 'undertake the admission induction program in their first week of

custody in which a full risk and needs assessment is carried out'.<sup>1148</sup> The Government stated that '[s]afety is ultimately the deciding factor for each individual unit and program placement' and that sexual and physical safety is taken into account during the risk assessment.<sup>1149</sup>

However, the Centre's current admission process does not include a screening assessment for harmful sexual behaviours.<sup>1150</sup> What is needed is a screening assessment based on an accepted contemporary model of harmful sexual behaviours that admission staff can use—in conjunction with proper training—to identify children and young people who may be likely to engage in harmful sexual behaviours. Those children and young people should immediately be referred to clinical staff for a clinical assessment to understand the child's risks and needs and inform placement decisions, safety planning and therapeutic interventions. The 'Assessment Intervention Moving on (AIM)' assessment framework currently used by the Sexual Assault Support Service is an example of a clinical assessment.<sup>1151</sup>

Also, given the heightened risks of harmful sexual behaviours in youth detention populations, policies and practices need to go beyond an initial assessment and instead provide a framework for recognising and responding to inappropriate and harmful sexual behaviours young people may display throughout their time in detention. The Hackett Harmful Sexual Behaviours Continuum, True Relationship Traffic Lights continuum or Paton and Bromfield Layered Continuum are examples used in Australia that provide a framework for understanding children's sexual behaviours and recognising where those behaviours have the potential to be harmful to the child displaying the behaviours or others.<sup>1152</sup>

### 8.4.3 Placement decisions

The National Royal Commission recommended that state and territory governments ensure placement decisions in youth detention are informed by an assessment that includes a child's vulnerability to sexual abuse or displaying harmful sexual behaviours.<sup>1153</sup> It identified that children and young people were more at risk from harmful sexual behaviours in youth detention when they were placed with older children and young people or when female children and young people were housed in a predominantly male environment.<sup>1154</sup>

The National Royal Commission acknowledged how challenging placement of children and young people in youth detention centres can be, particularly where there are limited accommodation options, such as having only one detention centre or one that is very small.<sup>1155</sup> We also acknowledge that staff shortages and high detainee-to-staff ratios can complicate placement decisions.

On 31 May 2022, the Department introduced a new *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* ('Unit Placement

Procedure’).<sup>1156</sup> The Unit Placement Procedure acknowledges that decisions about unit placement are ‘critical, as placement decisions can affect a young person’s health and wellbeing by either increasing or decreasing the risk of immediate or future harm’.<sup>1157</sup> The following ‘critical requirements’ are identified in the Unit Placement Procedure ‘in order to ensure the safety of young people’:

All new arrivals will be housed in the admission induction unit.

Male and female detainees will be housed separately. Detainees that identify as transgender will guide their unit placement.

If deemed safe, young people from Aboriginal and Torres Strait Islander backgrounds should room share.

Placement decisions about young people must be made in the best interests of all young people at the Centre.<sup>1158</sup>

The Unit Placement Procedure describes the responsibility of the ‘Risk Assessment Process Team’ to consider ‘the best interests of all affected young people’ when determining placements for children and young people in the Centre.<sup>1159</sup> While the team must generally consider ‘[s]afety and security needs or risks’, and gender and ‘[r]elationship dynamics in the Unit’, the Unit Placement Procedure does not mention the risk of harmful sexual behaviours.<sup>1160</sup> We also consider that the Unit Placement Procedure lacks clarity on what ‘operational considerations’ may influence decisions about unit placement and who will make and review such decisions.

As acknowledged in the Fifth Annual Report, safety considerations should outweigh operational needs in making decisions about the placement of children and young people within detention facilities.<sup>1161</sup> As discussed, we consider that a screening and assessment process that informs the approach to unit and program assignments should occur at admission to minimise risk of the child experiencing or displaying harmful sexual behaviours.

#### 8.4.4 Supervision

The National Royal Commission found that inadequate supervision in youth detention facilities provided more opportunity for harmful sexual behaviours.<sup>1162</sup> Poor supervision was a factor that contributed to a number of the incidents of harmful sexual behaviours in Ashley Youth Detention Centre described in our case studies, especially where other risk factors were present—such as younger children being left unsupervised with older children, or a girl being left unsupervised with boys.<sup>1163</sup>

Installing closed-circuit television cameras could be an alternative to in-person supervision. However, a number of the instances of harmful sexual behaviours described in the case studies occurred in the presence of closed-circuit television cameras, which may indicate that this form of supervision is less effective at deterring harmful sexual



behaviours and should not be relied on as a preventive practice in preference to in-person staff supervision. In Section 4.7, we discuss staffing shortages at Ashley Youth Detention Centre and make recommendations for staff recruitment.

## 8.5 Responding to harmful sexual behaviours

There must be a clear process for responding to incidents of harmful sexual behaviours when they occur in youth detention or other residential youth justice facilities.

The National Royal Commission stated that an institution's response to an incident of harmful sexual behaviour should involve:

- monitoring the safety and wellbeing of the children and young people involved as well as any children and young people who witnessed the incident
- complying with reporting obligations
- communicating with the children and young people involved and their carers
- documenting and sharing information where necessary.<sup>1164</sup>

We discuss each of these elements of a good response to harmful sexual behaviours in the following sections.

In its Fifth Annual Report, the Tasmanian Government said 'work has been undertaken to ensure that a risk sensible approach is applied to sexualised behaviours onsite with these behaviours not normalised' in Ashley Youth Detention Centre.<sup>1165</sup> It is not clear from that report what specific actions the Tasmanian Government has taken to ensure that outcome.

We note that sexualised behaviours occur on a continuum and, therefore, the response should be appropriate to the severity and chronicity of the behaviour.<sup>1166</sup> Lower-level behaviours such as sexualised talk and simulated masturbation in public settings can be managed by staff redirecting and reminding young people of what is appropriate behaviour. In so doing, staff support a norm for the culture of the facility that discourages young people from displaying more harmful sexualised behaviours.<sup>1167</sup> However, more serious behaviours require a more therapeutic response for the young people involved. The following principles should guide the response.

### 8.5.1 Child wellbeing

We heard that when Erin (a pseudonym) was sexually assaulted in Ashley Youth Detention Centre by a group of young people, she received no therapeutic response to the trauma.<sup>1168</sup> Children and young people who have been affected by harmful sexual behaviours—whether they engaged in, experienced or witnessed the behaviours—need to have timely, clinically supervised access to appropriate support for their wellbeing

following an incident.<sup>1169</sup> As discussed in Chapter 21, there are many benefits associated with sexual assault counselling and therapeutic interventions for harmful sexual behaviours being delivered to children in detention by community-based services. For example, with effective treatment, children's risk of continuing to display harmful sexual behaviours is significantly reduced.<sup>1170</sup>

Secretary Pervan told us that, following evidence from the Sexual Assault Support Service at our hearings in May 2022, senior staff from Ashley Youth Detention Centre established a formal arrangement for consulting with the Sexual Assault Support Service 'to provide recommendations for identifying, preventing and responding to harmful sexual behaviour, and child sexual abuse more generally'.<sup>1171</sup> He said that 'the Sexual Assault Support Service is now available to support young people who were victims or witnesses' of harmful sexual behaviours in the Centre and that a private psychology practice provides three hours per week of psychology services to those young people via a digital platform.<sup>1172</sup> He told us that a child who has experienced harmful sexual behaviours would receive therapeutic support from the private psychology practice, the Centre's nurse and the visiting doctor.<sup>1173</sup>

While this information is promising, we remain cautious. Renae Pepper, Senior Practitioner and Psychologist, Sexual Assault Support Service, expressed concern that the punitive approach at Ashley Youth Detention Centre (discussed in Section 4.2.2) was at odds with a therapeutic approach to responding to harmful sexual behaviours.<sup>1174</sup> This tension must be resolved if children and young people in detention are to receive appropriate interventions for harmful sexual behaviours.

Ideally, where longer-term sexual assault and harmful sexual behaviours clinical supports are required, they should be provided by clinical specialists outside the facility, who can continue to provide treatment following the young person's release from detention. This is important given the need to develop a therapeutic relationship for successful intervention and given that many young people are in detention for relatively short periods.<sup>1175</sup>

### **8.5.2 Communicating with children, young people and their carers**

As discussed in Section 10, a child-focused complaints process involves the child and keeps them informed of the outcome.<sup>1176</sup> Furthermore, parents and guardians should also be kept informed of the wellbeing of their child in detention or another residential youth justice facility. The harmful sexual behaviours policy should outline how staff at such facilities will communicate with parents, carers or guardians of the children involved.<sup>1177</sup>

### **8.5.3 Reporting obligations**

The current procedure for reporting incidents at Ashley Youth Detention Centre directs staff to record the incident and report it through the Centre Support Team and to the

Centre Manager for more serious incidents.<sup>1178</sup> The procedure instructs only the Centre Manager to ‘make notifications to relevant parties’, although it does not specify the parties involved.<sup>1179</sup> However, as discussed in Section 10.2.7, the Department’s *Reporting Concerns* fact sheet advises staff of their mandatory obligations to report suspected child abuse or neglect to the Advice and Referral Line under the Children, Young Persons and Their Families Act.<sup>1180</sup> The fact sheet specifically includes harm that can occur ‘between children and young people in any setting’ as reportable to the Advice and Referral Line, and ‘[i]f the concerning behaviour is criminal in nature, then it must also be reported to Tasmania Police’.<sup>1181</sup>

To ensure incidents of harmful sexual behaviours are reported, the harmful sexual behaviours policy should include how mandatory reporting requirements are to be fulfilled. This should be aligned with the role and responsibilities of different agencies in responding to harmful sexual behaviours outlined in the statewide framework for preventing, identifying and responding to harmful sexual behaviours, which we recommend in Chapter 21 (Recommendation 21.8). These requirements should then be reinforced through staff training and professional development. However, as neither the Advice and Referral Line nor Tasmania Police are likely to have cause to respond in all situations of harmful sexual behaviours, a facility-led, clinically directed response is also required. The detailed policy, protocols and guidance on harmful sexual behaviours in youth detention and other residential youth justice facilities should describe this response.

Also, there should be appropriate departmental oversight of responses to harmful sexual behaviours in detention and other residential youth justice facilities. We recommend that management of the facility reports all incidents of harmful sexual behaviours to the Harmful Sexual Behaviours Support Unit to access advice, support and guidance from the unit and to enable data on harmful sexual behaviours in residential youth justice facilities to be included in the Department’s monitoring and oversight of harmful sexual behaviours through the new Quality and Risk Committee (refer to Recommendation 9.5 in Chapter 9).

Given the history of inadequate responses by previous departments to such incidents, independent oversight is also required. In Chapter 18, we recommend establishing a new Commission for Children and Young People, which will oversee youth detention and the youth justice system. We consider that the Secretary of the Department for Education, Children and Young People should notify the new Commission for Children and Young People of incidents involving harmful sexual behaviours in detention and other residential youth justice facilities, and of the Department’s responses. The new Commission for Children and Young People should have the power to compel the Department to provide information on its responses to such incidents.

#### 8.5.4 Staff training and professional development

Staff in a residential youth justice facility need to understand trauma-informed care, how to identify and prevent harmful sexual behaviours, and how to respond to the needs of children and young people in that setting who have displayed or experienced inappropriate and harmful sexual behaviours.<sup>1182</sup>

We heard from former clinical staff that Ashley Youth Detention Centre staff lacked understanding of what constituted normal, inappropriate or harmful sexual behaviours among children and young people.<sup>1183</sup> We heard that staff relied on personal opinion to decide whether a behaviour was concerning, leading to an instance of harmful sexual behaviour being dismissed as ‘locker room’ behaviour and not serious.<sup>1184</sup> Consequently, children and young people at the Centre have not always received the help they needed in relation to harmful sexual behaviours, which increases the risk of future harmful sexual behaviours.<sup>1185</sup>

We were told that there had been no training for staff about harmful sexual behaviours until after the beginning of our Commission of Inquiry in late 2021, when the Sexual Assault Support Service provided some training sessions and consultations to Ashley Youth Detention Centre staff through its newly funded ‘Prevention, Assessment, Support and Treatment’ program.<sup>1186</sup> Feedback from staff at that time was that the training did not translate appropriately to a custodial environment.<sup>1187</sup>

We are pleased to hear that staff at Ashley Youth Detention Centre have now received training in harmful sexual behaviours. However, based on the feedback reported to the Sexual Assault Support Service, we remain concerned about how this training has been received or how effective it has been. We agree with Ashley Youth Detention Centre staff that training in harmful sexual behaviours needs to be tailored to the detention population and context. To be most effective, such training should be part of a wider strategy to create a child safe culture in youth detention, including transitioning to a therapeutic, child-focused youth detention system (refer to Section 6) and implementing measures to address staff culture and resistance to change (refer to Section 4.7).

#### 8.5.5 Policy and procedures

A former Manager, Professional Services and Policy at Ashley Youth Detention Centre advised that during her time at Ashley Youth Detention Centre (2017 to 2019), the Centre did not have any policies or procedures to guide staff responses to harmful sexual behaviours.<sup>1188</sup> She told us that notifications of incidents to Tasmania Police or the Advice and Referral Line were not supported and she did not believe that ‘officials in [Ashley Youth Detention Centre] were clear on [their mandatory reporting] obligations’.<sup>1189</sup>

Secretary Pervan told us that Ashley Youth Detention Centre ‘does not have a policy specifically concerning child sexual abuse or harmful sexual behaviours’ but that the ‘existing practices and policies concerning incidents and reporting cover instances of

harmful sexual behaviour'.<sup>1190</sup> The Department told us that the Practice Framework and the Learning and Development Framework are the policies underpinning the Centre's approach to harmful sexual behaviours.<sup>1191</sup>

These documents indicate that trauma-informed care is to be provided to children and young people in Ashley Youth Detention Centre. However, they do not address understanding and responding to harmful sexual behaviours. As noted in Section 6.3.3, the Australian Childhood Foundation is reviewing the Practice Framework and the Learning and Development Framework.<sup>1192</sup>

As discussed in Section 10.2.4, the purpose of the *AYDC Incident Reporting Procedure* is to outline the steps that staff must take 'following an incident that has arisen from the behavior/s of a young person or multiple young people'.<sup>1193</sup> A central focus of this procedure is determining whether any young person involved in the incident has committed a 'detention offence' under the Youth Justice Act.<sup>1194</sup> We do not consider the *AYDC Incident Reporting Procedure* to be appropriate to guide responses to prevent and respond to harmful sexual behaviours.

Harmful sexual behaviours were a well-known risk for children and young people in institutional settings before the National Royal Commission and became even more clearly recognised after that Commission published its final report in 2017. It is concerning, however, that training for Ashley Youth Detention Centre staff on harmful sexual behaviours did not begin until August or September 2021 as discussed above, well after the start of our Commission of Inquiry. Children and young people in detention deserve protection from other children and young people who have displayed harmful sexual behaviours. Moreover, children and young people in detention who have displayed harmful sexual behaviours need and deserve access to interventions to help them change.

The absence of a clear policy on harmful sexual behaviours at Ashley Youth Detention Centre reflects the Tasmanian Government's general lack of a coordinated approach and response to harmful sexual behaviours (as discussed in Chapter 21 on therapeutic services). This omission needs to be rectified as a matter of priority to protect children and young people in detention and for children and young people who have displayed harmful sexual behaviours to receive appropriate treatment and support. In detention, attention must be paid to fundamentally shifting the culture from normalising and minimising harmful sexual behaviours to assuming responsibility for preventing and responding therapeutically to harmful sexual behaviours.

This changed culture should be supported by a comprehensive policy, protocols and practice guidance on addressing harmful sexual behaviours in youth detention that complements the child-focused, therapeutic model of care for detention that we recommend in Section 6.3.4.

Policies and procedures should include processes:

- for operational staff to screen young people for harmful sexual behaviours during their induction to the facility, identifying those young people who need further assessment and referring them for clinical assessment
- for clinical staff to assess young people identified during screening for their risks and needs in relation to harmful sexual behaviours, and develop a management plan that includes safety planning and therapeutic responses
- by which placement decisions and supervision requirements are informed by clinical assessment and safety planning in relation to harmful sexual behaviours.

Policies will need to balance the safety of young people in detention with the risks of imposing restrictive practices on the young person who has displayed harmful sexual behaviours (refer to Section 9 of this chapter for more information about restrictive practices).

### **Recommendation 12.30**

1. The Harmful Sexual Behaviours Support Unit (Recommendation 9.28) should develop detailed youth justice-specific policies, protocols and practice guidelines to support best practice responses to harmful sexual behaviours in youth detention and other residential youth justice facilities.
2. All incidents of harmful sexual behaviours in youth detention or other residential youth justice facilities should be reported to:
  - a. the Harmful Sexual Behaviours Support Unit to enable data on harmful sexual behaviours in youth detention and other residential youth justice facilities to be included in the Department for Education, Children and Young People's monitoring and oversight of harmful sexual behaviours through the new Quality and Risk Committee (Recommendation 9.5)
  - b. the Commission for Children and Young People (Recommendation 18.6).
3. The Department should explore the potential to implement Power to Kids (or another program or approach with comparable components) in youth detention and other residential youth justice facilities as a supplementary strategy to address the heightened risk of harmful sexual behaviours in those settings and take a proactive approach to prevention.

4. The Tasmanian Government should ensure measures are in place to facilitate timely access to specialist therapeutic interventions for children in youth detention displaying or harmed by harmful sexual behaviours. Where treatment is likely to extend beyond their custodial sentence this should be provided by a clinician external to the detention centre who can continue the treatment after the child is released from detention.

## 9 Searches, isolation and use of force in youth detention

As highlighted throughout this volume, the National Royal Commission referred to the ways in which closed institutions such as youth detention facilities can become ‘alternative moral universes’, whereby norms and rules are established and maintained wholly within the institution.<sup>1195</sup> Where the institution fosters a culture of tolerance for humiliating and degrading children and young people, routinely using force or violence, or otherwise normalises aggression, acts of sexual abuse against children and young people are more common.<sup>1196</sup> Research also reveals that in institutions where the routine use of force or violence against children and young people is permitted, staff can become desensitised, making it easier for them to minimise or tolerate ongoing harm, including sexual harm, to children and young people.<sup>1197</sup>

As described in Chapter 11, Case studies 1, 3 and 4, it was apparent that the inappropriate and, possibly unlawful, use of searches, isolation and force at Ashley Youth Detention Centre occurred as part of a broader culture that enabled abuse, including sexual abuse, of children and young people in detention. We heard from victim-survivors that searches, isolation, use of force and child sexual abuse rarely occurred discretely; rather, two or more of these practices were often part of the same interaction with a child or young person. As identified in victim-survivor accounts outlined in the case studies:

- Strip searches described to us were, at times, a form of sexual abuse.
- Strip searches were often conducted prior to a child or young person being isolated and during their isolation.
- Force and restraints were used on children or young people when conducting strip searches and to isolate them.
- Force and restraints were used to disable a child or young person, so they could be sexually abused.
- Isolation and violence were threatened if a child or young person refused to comply with staff directions, including directions to submit to sexual abuse.



- Isolation and violence were threatened or used as punishment of a child or young person if they reported sexual or physical abuse.

These case studies suggest that the powers to search, isolate or use force against a child or young person in detention—which may be legitimately exercised in narrow and clearly defined circumstances—can be abused if the culture in detention enables it, staff do not have the necessary skills to avoid restrictive practices, oversight is impeded or lacking, children and young people feel unable to complain about mistreatment, and authorising laws and procedures do not include adequate safeguards.

Recommendations in other sections of this chapter are designed to achieve cultural change in youth detention (Section 4), ensure staff have the necessary skills to engage with children and young people constructively (Sections 4 and 6), improve complaints mechanisms and the Department’s responses to incidents affecting children’s safety in detention (Section 10) and strengthen external oversight of practices in detention (Section 11). In particular, we recommend changes to:

- ensure youth workers are appropriately qualified, trained and supported to deliver a therapeutic model of care to children and young people in detention, with enough staff to keep children and young people safe (Recommendation 12.9)
- ensure staff in youth detention facilities have the skills needed to undertake trauma-informed interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to force or other restrictive practices (Recommendation 12.18)
- establish an independent community visitor scheme for children and young people in detention (Recommendations 9.34 and 12.36)
- strengthen leadership in the youth detention system (Recommendation 12.6).

In addition, in Section 4.6.3, we recommend that the Department develops an empowerment and participation strategy for children and young people in detention that includes mechanisms to ensure children and young people in detention are aware of their rights (Recommendation 12.8). This should include awareness of their rights in relation to searches, isolation and use of force.

The regulatory framework for searches, isolation and use of force comprises the Youth Justice Act, the *Inspection Standards for Youth Custodial Centres in Tasmania* (‘Inspection Standards’) and custodial policies and procedures issued by the Department. In this section, we examine this framework, together with practices in relation to searches, isolation and the use of force in youth detention. We recommend measures to:

- clarify and strengthen relevant legislative provisions and custodial procedures
- improve reporting and oversight of searches, isolation and use of force

- ensure staff who use these practices and those who monitor and oversee their use have a strong understanding of relevant legislative, procedural and practice requirements.

As noted in the introduction to Volume 5, the Order establishing our Commission of Inquiry directed us to inquire into responses to allegations of child sexual abuse at Ashley Youth Detention Centre. However, we note that children and young people are also detained in adult custodial facilities that have been declared to be youth detention centres, including Hobart Reception Prison, Launceston Reception Prison and Risdon Prison.<sup>1198</sup> Children and young people can also be transferred from Ashley Youth Detention Centre to an adult prison facility or otherwise detained in an adult prison facility in certain circumstances (this is discussed in Section 6.9). We also note that the provisions of the Youth Justice Act in relation to searches of children and young people apply to prisons, reception prison watch-houses and police watch-houses, as well as detention centres.<sup>1199</sup>

Children and young people detained in custodial facilities other than Ashley Youth Detention Centre are subject to procedures and practices relating to searches, isolation and the use of force that may carry the same risk of abuse as in the Centre.<sup>1200</sup> While we have not inquired into the treatment of children and young people in adult custodial facilities, many of the issues raised in this section will also have implications for children and young people in those settings. We encourage the Government to consider our recommendations broadly and approach implementation consistently in relation to children and young people in all custodial settings in Tasmania.

We consider searches, isolation and use of force in turn.

## 9.1 Searches of children and young people

This section considers searches of children and young people in detention. It does not consider other searches carried out in detention, such as searches of children and young people's rooms.

As noted in Chapter 10, we sometimes use the term 'strip search' in this volume because this is the phrase victim-survivors commonly use when referring to a search involving any removal of clothing, whether partial or full. However, we note that in the Youth Justice Act and custodial standards and procedures, this practice is commonly referred to as an 'unclothed search', with a distinction drawn between partially clothed and fully unclothed searches. In this section, we refer to 'strip searches', 'fully unclothed searches' and 'partially clothed searches', depending on the context. We also refer more broadly to 'personal searches' in our discussion of current custodial procedures.

### 9.1.1 What we heard about strip searches in detention

As outlined in Chapter 11, Case study 1, victim-survivors told us about their experiences of strip searches at Ashley Youth Detention Centre. These experiences included:

- being routinely strip searched on admission to the Centre
- being strip searched while in isolation or while restrained
- being threatened with strip searches to ensure compliance with staff commands
- female detainees being strip searched by male staff
- staff inserting their fingers into the anus of young people during a strip search
- strip searches contributing to long-term adverse effects on a young person's mental health and wellbeing.

As noted in Chapter 11, Case study 1, many of these practices amount to child sexual abuse.

We received evidence from the Commissioner for Children and Young People, Leanne McLean, that, in the six-month period from 1 June 2018 to 30 November 2018, there were 203 strip searches conducted on children and young people detained at Ashley Youth Detention Centre.<sup>1201</sup> Despite this alarmingly high number of strip searches, no contraband was recovered from any of the searches.<sup>1202</sup>

The Custodial Inspector completed an inspection of youth custodial services in Tasmania in 2018.<sup>1203</sup> The Custodial Inspector's report recommended that the (former) Department of Communities:

- consider installing metal detectors and x-ray machines at the Admissions Unit to prevent contraband entering Ashley Youth Detention Centre and to minimise the need for personal searches
- carry out unclothed searches of children and young people on the basis of a rigorous risk assessment rather than on a routine basis.<sup>1204</sup>

### 9.1.2 Youth Justice Act

As outlined in Chapter 10, the Youth Justice Act contains provisions relevant to searches of children and young people in detention.

Before December 2022, the Youth Justice Act allowed a detention centre manager to submit a child or young person to a search for prohibited items as soon as possible after admission or return after a temporary leave of absence from the detention facility, and at any other time when there were reasonable grounds to believe that the child or young person may have had contraband in their possession, or in the manager's opinion, it was necessary to conduct the search in the interests of security.<sup>1205</sup> As a result of

December 2022 amendments to the Youth Justice Act, references to searches being conducted on admission or after temporary leave have been removed.<sup>1206</sup>

Under the new provisions, a ‘search officer’ (a person authorised to conduct a search) must not conduct a search of a child or young person unless the search officer believes on reasonable grounds that the search is ‘necessary for a relevant search purpose’ and the type and manner of search are proportionate to the circumstances.<sup>1207</sup>

The Youth Justice Act defines a ‘relevant search purpose’ as follows:

- to ensure the safety of the child or young person or another person
- to obtain evidence relating to the commission of an offence or to prevent the loss or destruction of evidence relating to an offence
- to ascertain whether the child or young person has possession of a concealed weapon, or another article capable of being used as a weapon, to inflict injury or to aid in escape from custody
- to ascertain whether the child or young person has possession of drugs or prohibited items, or
- for a clothed search, to remove into safe keeping any articles in the possession of the child or young person.<sup>1208</sup>

The Youth Justice Act now includes the following ‘hierarchy’ of searches, from the least to the most intrusive:

- a search (which may be a search by way of a scanning device) that involves no touching of a child or young person or of clothing they are wearing
- a search that includes ‘minimal touching’ of the child or young person or their clothing
- a search that includes removing some clothing
- a search that includes more than minimal touching of the child or young person or their clothing
- an ‘unclothed search’, which is defined as a search that requires the child or young person’s torso or genitals to be exposed to view, or their torso or genitals, clothed only in underwear, to be exposed to view.<sup>1209</sup>

A ‘body cavity search’ is not permitted.<sup>1210</sup>

The Youth Justice Act provides that a search officer must not conduct an unclothed search of a child or young person unless the ‘relevant authorising officer’ (the Secretary

or the detention centre manager) has authorised the search.<sup>1211</sup> A relevant authorising officer must not authorise an unclothed search unless they believe on reasonable grounds that:

- the search is necessary for a relevant search purpose
- the type of search, and the manner of search, are proportionate to the circumstances
- despite being the most intrusive type of search, an unclothed search is necessary and reasonable to achieve a relevant search purpose
- the search is to be conducted in the least intrusive manner that is necessary and reasonable to achieve a relevant search purpose.<sup>1212</sup>

The Youth Justice Act also includes principles for carrying out searches. Among other matters, the search officer must ensure:

- the search is conducted in a manner that is consistent with retaining the child or young person's dignity and self-respect, and that minimises any trauma, distress or harm
- the search is the least intrusive type of search and is conducted in the least intrusive manner necessary and reasonable to achieve a relevant search purpose for which the search is conducted
- the search is completed as quickly as is reasonably possible
- the search is conducted in circumstances that allow reasonable privacy for the child or young person
- they do not remove, or require the child or young person to remove, more clothing than is necessary and reasonable.<sup>1213</sup>

The Youth Justice Act now also requires that a search involving touching or the removal of any clothing be conducted by a search officer of the same gender as the young person, or if the youth is transsexual, transgender or intersex, a person of the gender requested.<sup>1214</sup> For unclothed searches conducted in the presence of another person (an observer), the same gender requirements apply to that observer.<sup>1215</sup> The only exception to these requirements is where it is 'not reasonable or practicable' for them to apply 'because of the urgency with which the search is required in order to address the risk of harm or trauma to the youth or another person'.<sup>1216</sup>

The Youth Justice Act permits a search officer to use force to conduct the search, but only where this is 'the only means, in the circumstances, by which the search can reasonably be conducted'.<sup>1217</sup> The officer must ensure that, if force is used, it is the least amount of force that is reasonable and necessary to enable the search to be conducted.<sup>1218</sup>

Under the 2022 amendments to the Youth Justice Act, a record of each search must be kept in a search register established and maintained by the Secretary, with details including the degree of the intrusiveness of the search and any force used to conduct the search.<sup>1219</sup> The register must be made available for inspection by the Ombudsman, the Custodial Inspector and any approved or prescribed person or body (of which there are none currently).<sup>1220</sup>

### 9.1.3 Inspection standards on searches

Following the 2022 amendments, the Youth Justice Act now more closely reflects the Inspection Standards on searches. According to these standards:

- Searches of a young person must be conducted safely and ‘only when reasonable and necessary’, and they must be proportionate to the situation.<sup>1221</sup>
- Pat searches and searches using metal detectors should be undertaken first. Unclothed searches should be a last resort, and cavity searches should never be conducted.<sup>1222</sup>
- Unclothed searches should not be routinely conducted on entry and exit to a detention facility where a young person has been in a secure vehicle while off the premises.<sup>1223</sup>
- Staff should be appropriately trained to conduct unclothed searches.<sup>1224</sup>
- The staff member conducting the unclothed search should be the same sex as the young person unless the young person identifies as transgender, in which case the young person should nominate the gender of the person they want to conduct the search.<sup>1225</sup>

### 9.1.4 Custodial procedures on searches

The Department’s *Personal Searches of Young People Detained at AYDC Procedure* (‘Search Procedure’), effective from February 2023, sets out requirements for ‘personal searches’ of children and young people in detention.<sup>1226</sup> This procedure replaced an earlier procedure on searches dated September 2019, which in turn replaced a procedure introduced in 2012.<sup>1227</sup> We acknowledge that there have been several significant changes to search procedures since 2012, many of which occurred in 2019—these included introducing the requirement for ‘reasonable grounds’ for a search, prohibiting fully unclothed searches and requiring modesty gowns for children and young people if they are asked to remove clothing.<sup>1228</sup> Nevertheless, here we focus on the current procedure.

One of the purposes of the Search Procedure is to ensure that, ‘when required, searches of young people are conducted in a safe and least intrusive manner, while maintaining the privacy, dignity and rights of the young person’.<sup>1229</sup> The Search Procedure recognises

that '[a] search is an infringement on a person's right to privacy' and that a search that does not comply with legal and procedural requirements 'has the potential to be considered trespass and/or assault'.<sup>1230</sup>

The Search Procedure defines a 'personal search' as:

- a metal detector search, which involves a child or young person walking through a large metal detector while fully clothed and does not require them to be touched<sup>1231</sup>
- a wand search, which involves using an approved hand-held metal detector on a fully clothed child or young person and does not require them to be touched<sup>1232</sup>
- a pat search, which involves 'the careful patting down of a young person's clothed body after the removal of outer garments (such as a coat or jacket) and shoes and socks' to feel for any hidden items<sup>1233</sup>
- a partially clothed search, which involves 'visual examination of the upper body after removal and searching of upper garments, followed by visual examination of the lower body after return of the upper garments and the removal of lower garments'.<sup>1234</sup>

The Search Procedure:

- prohibits '[f]ully [u]nclothed' searches, defined as asking a child or young person to remove all their clothing at the same time<sup>1235</sup>
- prohibits cavity searches, defined as 'a visual, manual or instrument inspection of a young person's body cavities including mouth, ears, vaginal, or anal orifices'<sup>1236</sup>
- prohibits any personal search being undertaken 'automatically', instead requiring all personal searches to be based on 'reasonable grounds'<sup>1237</sup>
- specifies that the type of search undertaken 'must be the least intrusive in accordance with the risk posed'<sup>1238</sup>
- states that partially clothed searches 'must only be undertaken as a last resort, in circumstances where all reasonable grounds indicate that the young person is carrying a prohibited and/or unauthorised item' and can only occur with approval from the Director, Custodial Youth Justice<sup>1239</sup>
- enables force to be used to undertake a search, but only as a last resort, where 'all other strategies, such as negotiation, have failed', and subject to 'prior approval of the Director with sufficient intelligence to support the request'.<sup>1240</sup>



The Search Procedure requires operational staff to take the following steps:

- Assess whether reasonable grounds exist for a personal search—in undertaking this assessment, staff must consider ‘the history, behaviour and situational factors associated with the young person’, including their age and gender, their behaviour or demeanour on admission and whether they have a history of drug or alcohol use.<sup>1241</sup>
- ‘[C]onsider the level of risk’ associated with the search—this is ‘a matter of professional judgement made on a case-by-case basis’ and involves using a ‘hierarchy of risk assessment tool’ (we were not provided with this tool).<sup>1242</sup>
- Determine the most appropriate type of search to be conducted based on the risk—as noted, this must be ‘the least intrusive that is necessary and reasonable in the circumstances’.<sup>1243</sup>
- Seek approval for the search from the ‘relevant Delegate’—for partially clothed searches, this is the Director, Custodial Youth Justice, and for other personal searches this is the ‘Youth Worker, Operations Coordinator’.<sup>1244</sup>
- Inform the young person of the intent to conduct a search and the reasons for the search, explain how the search will be undertaken and offer an opportunity for the young person to ask questions.<sup>1245</sup>
- Carry out the search ‘in a location and manner that maintains the young person’s dignity’ and meets specified requirements—for example, two staff must be present for all searches.<sup>1246</sup>
- Record information about the search, including the grounds for the search, the type of search based on the risk assessment, and approval for the search in ‘the Search Register located in each unit folder on O: Drive’, which is presumably a shared drive.<sup>1247</sup>

The requirements in the Search Procedure about the gender of the staff members carrying out or observing a search do not entirely reflect the requirements in the Youth Justice Act. For example, for partially clothed searches, the Search Procedure provides that:

Every effort should be made to ensure that two staff of the same gender [as the young person] are available. In exceptional circumstances, the Observer may be of the opposite sex if two same-sex officers are not available.<sup>1248</sup>

The Search Procedure does not define ‘exceptional circumstances’.

In contrast, as noted in Section 9.1.2, the Youth Justice Act requires an observer to be of the same gender as the young person (or of the gender requested if the young person is transsexual, transgender or intersex), subject only to a limited exception based on the urgency of the need for the search ‘in order to address the risk of harm or trauma’ to the young person or another person.

According to the Department’s Keeping Kids Safe Plan, Ashley Youth Detention Centre provides the search register to the Commissioner for Children and Young People and the Custodial Inspector on a monthly basis.<sup>1249</sup>

The Keeping Kids Safe Plan also states that, once updated, the Search Procedure would be implemented with staff.<sup>1250</sup>

### 9.1.5 Understanding and implementation of search procedures in detention

We asked managers and staff at Ashley Youth Detention Centre about their understanding of procedures and practices in relation to searches of children and young people at the Centre, noting that the procedures have changed over time.

Former Centre Manager Patrick Ryan told us that when he first started working at Ashley Youth Detention Centre in 2017, the policy on strip searches was ‘prescriptive’ and required children and young people to be strip searched ‘when they’re coming in from Police custody, they’d had a visitor, when they’d been off site’.<sup>1251</sup> Mr Ryan commented that ‘the policy was too rigid’; that is, staff ‘were strip searching residents too often’.<sup>1252</sup>

We asked the Assistant Manager at Ashley Youth Detention Centre, Fiona Atkins, about the changes introduced in 2019 for strip searches at Ashley Youth Detention Centre (outlined in Section 9.1.4). She responded:

One major change was in relation to requiring reasonable cause to perform a search of young people instead of automatically searching young people. For example, in respect of a new admission, you would have to provide a reason for the search such as a history of contraband. The other major change was the introduction of the vanity gown for searches and ensuring that young people were asked if they wanted to use it if a search was required.<sup>1253</sup>

Consistent with this, Centre Manager Stuart Watson, who started in the role in 2020, told us that ‘searching is something that is evidence-based or information-based, or there’s got to be a reason. Searching is not mandatory, it’s something that is not routine’.<sup>1254</sup>

When queried about the safeguards in place at Ashley Youth Detention Centre to protect young people from being subjected to searches that were not authorised, Mr Watson told us that if a child or young person at the Centre was subjected to an unauthorised search, ‘[t]hey can pick up the phone pretty much at any time and ring the Commissioner [for Children and Young People] directly’.<sup>1255</sup> He explained that a young person can also complain to the staff members conducting the search, the Operations Coordinator or other members of Ashley Youth Detention Centre staff.<sup>1256</sup> Mr Watson told us that ‘[e]nsuring that a young person has multiple avenues for complaining about an inappropriate or unauthorised search is an important part of a system of checks and balances on searches’.<sup>1257</sup>

Mr Watson also said that ‘if staff see something that’s not appropriate, they can complain’.<sup>1258</sup>

We also received evidence from current and former Ashley Youth Detention Centre staff about their understanding of strip searches. A staff member told us that although reference to modesty gowns was included in the procedure introduced in 2019, the gowns were not available to children and young people until 2021.<sup>1259</sup>

A Department of Communities issues briefing to the then Minister for Children and Youth, unsigned but noted as ‘cleared’ by Secretary Pervan in December 2021, referred to the following allegation raised by the then Leader of the Tasmanian Greens Party, Cassy O’Connor, in December 2020 regarding strip searches at Ashley Youth Detention Centre:

A PIN [Provisional Improvement Notice] should go to WorkSafe, when breaches occur. Policy is when children are searched, modesty gown must be used (re Children’s Commissioner recommendation). Workers lodged a PIN because there are no gowns (in last 12 months).<sup>1260</sup>

The briefing stated that, in January 2020, an Ashley Youth Detention Centre Health and Safety Representative had lodged a Provisional Improvement Notice about concerns that the security of the Centre and the safety of staff were ‘potentially at great risk as a new search procedure [had] allegedly [been] implemented without adequate consultation or training’.<sup>1261</sup> According to the briefing, the Health and Safety Representative withdrew the notice following a meeting with Mr Watson ‘where additional strategies were agreed to address any training concerns’.<sup>1262</sup>

In his statement to our Commission of Inquiry, Mr Watson told us that modesty gowns were not being used when he started working at the Centre in January 2020 but that he later ensured staff were trained and the gowns were used.<sup>1263</sup> In May 2022, a staff member told us she had ‘only recently’ been informed by the ‘legal team in Hobart’ that her interpretation of the procedure introduced in 2019 was not correct and that a modesty gown was to be given to a young person to put on, so they could undress and dress again under it. This staff member stated that ‘[u]ntil then scrutiny from the legal department had been amiss’.<sup>1264</sup>

In October 2022, Secretary Pervan confirmed that routine strip searching of children and young people in detention had ceased and referred to funding for new technology to conduct searches:

Searches are sometimes required for safety and security reasons to prevent harmful items such as drugs and weapons from entering custodial facilities. The practice of routine strip searches of youth has already ceased in all custodial facilities in Tasmania. Changes to the Youth Justice Amendment (Searches in Custody) Bill 2022 formalises reform on searches of children. The Government is also investing in alternative security strategies such as body scanners that will minimise the reliance on more invasive search types. \$1.3 million was allocated in the 2022–23 State Budget to implement this technology in Tasmanian correctional facilities, including Ashley Youth Detention Centre.<sup>1265</sup>

### 9.1.6 Improving search practices in detention

We welcome the 2022 amendments to the Youth Justice Act and the recent changes to the custodial procedure on searches of children and young people in detention. We note that the Search Procedure includes some safeguards that are not contained in the Youth Justice Act—in particular, the requirement for authorisation for a partially clothed search to be sought from the Director, Custodial Youth Justice, rather than from the Centre Manager. While we consider that the higher level of approval is appropriate at this time, it may be that as the culture of Ashley Youth Detention Centre changes, it would be appropriate for authorisation for partially clothed searches to be provided by the Centre Manager. In Section 4.4.2, we recommend that the Centre Manager role be reclassified to at least a Senior Executive Service Level 1 (Director level) in the Tasmanian State Service (Recommendation 12.6). For these reasons, we do not recommend that the Youth Justice Act be amended to require the higher level of approval required by the Search Procedure.

The Search Procedure also includes a prohibition on fully unclothed searches, which we recommend be included in the Youth Justice Act.

We consider that the Search Procedure should be strengthened by: defining fully unclothed searches as a form of child sexual abuse; explicitly outlining a hierarchy of search options; aligning gender requirements for staff who conduct or observe searches with requirements in the Youth Justice Act; and specifying reporting requirements for searches (discussed below). The Search Procedure should also be made publicly accessible on the Department's website.

We welcome the Government's investment in body scanner technology to facilitate less intrusive searches of children and young people in detention. In implementing this technology at Ashley Youth Detention Centre or any future detention facility, the Government should ensure its use is balanced against respect for children and young people's privacy and dignity.

We also welcome the use of a 'hierarchy of risk assessment tool' to help operational staff assess the level of risk associated with a proposed search and to determine the least intrusive type of search necessary and reasonable in the circumstances. Staff must be properly trained in how to use this tool and it should be included in the Department's Practice Manual.

We are concerned about the lack of understanding of search procedures among staff, particularly in view of significant changes to procedures in and since 2019. It was not clear to us that staff had been properly trained on earlier updates to the procedure to ensure consistent understanding and practice for searches. We also note that, despite references to providing modesty gowns in the 2019 updates to the procedure, in practice, these were not provided until concerns were raised. In Section 9.4, we recommend joint training on searches for Ashley Youth Detention Centre staff, staff at

any new detention facility and relevant staff of the Youth Justice Services directorate of the Department for Education, Children and Young People, to ensure a shared understanding across detention facilities and the broader Department of laws, policies and procedures.

We consider that care should be taken not to place the onus on young people to complain after an unlawful or inappropriate search (although this option should always be available to them—refer to Section 10); rather, the onus must be on the Department and facility management to ensure searches are carried out lawfully and in line with custodial procedures, and to take prompt action if they are not.

Departmental and independent oversight of searches of children and young people in detention is essential. In Section 4.5.1, we discuss the previous lack of transparency in Ashley Youth Detention Centre’s operations, which limited the Department’s ability to monitor the safety of children and young people in detention.

We recommend that Ashley Youth Detention Centre (and any future detention facility) provides a monthly report to the Secretary on searches of children and young people in detention.

In Chapter 9, we recommend that the Department establishes a Quality and Risk Committee that is chaired by the Secretary and has monitoring functions for the out of home care system (Recommendation 9.5). We consider that this committee should also have some monitoring functions for youth detention and should receive quarterly reports on searches. These reports should include enough information to enable the Quality and Risk Committee to analyse and monitor trends in searches and identify any concerns in the treatment of children and young people. This should include the number of searches carried out, the type and purpose of each search, the grounds for each search, the risk assessment associated with each search, information on search authorisations and identification of any items recovered from the search.

We welcome the legislative requirement to maintain a search register that must be made available to oversight bodies. As noted, the Department provides the search register on a monthly basis to the Commissioner for Children and Young People and the Custodial Inspector. In Chapter 18, we recommend establishing a new Commission for Children and Young People, with monitoring and oversight functions for youth detention—we discuss these functions in Section 11.6 of this chapter. We recommend that the search register be provided to the Commission for Children and Young People, at a minimum, on a monthly basis to enable it to monitor searches of children and young people in detention.

## Recommendation 12.31

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act expressly prohibits fully unclothed searches of children and young people in detention.
2. The Department for Education, Children and Young People should:
  - a. introduce body scanner technology at Ashley Youth Detention Centre and include such technology in any facility designed to replace the Centre
  - b. update the Department's *Personal Searches of Young People Detained at AYDC* procedure to
    - i. define a fully unclothed search as a form of child sexual abuse
    - ii. explicitly outline the hierarchy of search options, from the least to the most intrusive
    - iii. align gender requirements for staff who conduct or observe searches with requirements in the *Youth Justice Act 1997*
    - iv. specify internal and external reporting requirements in relation to searches
  - c. publish the personal searches procedure on the Department's website
  - d. consider what search policies and procedures, if any, should apply in the proposed new assisted bail and supported residential facilities
  - e. ensure Ashley Youth Detention Centre (and any future detention facility) provides
    - i. monthly reports on searches of children and young people in detention to the Secretary
    - ii. quarterly reports on searches of children and young people in detention to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
    - iii. the search register and all relevant supporting documentation to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People.

## 9.2 Isolation

'Isolation' of children and young people in detention is defined in different ways and can cover a range of situations involving confining, secluding, separating or segregating a child or young person from other children and young people. In a 2016 report on human rights standards in youth detention facilities in Australia, the Australian Children's Commissioners and Guardians distinguished between the following practices:

- 'Seclusion', 'isolation', 'confinement' or 'separation'—this involves the involuntary placement of a child or young person in a room from which they are not able to leave.<sup>1266</sup>
- 'Segregation'—this involves limiting a child or young person's contact with certain peers in the facility (for example, by changing the child or young person's education and recreation times, so they do not encounter another child or young person) but does not necessarily involve placing added restrictions on their movements.<sup>1267</sup>
- 'Lockdown'—this involves keeping large groups of children in their rooms for periods of time, which is frequently used as part of a detention facility's safety and security management regime.<sup>1268</sup>

According to the Australian Children's Commissioners and Guardians, seclusion and segregation 'should not be used in any form on children with known psychosocial issues, indicators of self-harm, mental illness or other related vulnerabilities'.<sup>1269</sup>

As outlined in Chapter 10, under the Youth Justice Act, isolation is defined as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'.<sup>1270</sup> We discuss this definition in Section 9.2.4.

According to international human rights standards:

- The solitary confinement of a child in detention and any other punishment that may compromise the physical or mental health of a child are strictly prohibited.<sup>1271</sup> The United Nations has defined solitary confinement as confinement for 22 hours or more a day without meaningful human contact.<sup>1272</sup>
- Any separation of a child in detention from others must be 'for the shortest possible time and used only as a measure of last resort for the protection of the child or others'.<sup>1273</sup>
- Any disciplinary measures and procedures in detention should be consistent with upholding the inherent dignity of the child and 'the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person'.<sup>1274</sup>



### 9.2.1 What we heard about isolation practices in detention

As discussed in Chapter 11, Case study 3, we heard a range of evidence about isolation practices at Ashley Youth Detention Centre from victim-survivors and their families.

They described various experiences, including recollections of:

- different degrees or kinds of isolation, ranging from being held in a room alone to being confined to a unit with only staff
- at times, lengthy periods of isolation, including for a number of weeks
- inappropriate isolation being used for a range of reasons, including as part of the induction process, as a form of punishment for bad behaviour or self-harm, against victims of assault, or as retribution for making complaints
- poor isolation conditions, often with limited or no access to therapeutic programs, education, health care or enough food or bedding
- handcuffs and physical restraint being used to place a child or young person in isolation, or while they were in isolation
- isolation that traumatised and confused children and young people, including contributing to long-term negative effects on their mental health and wellbeing.

In Chapter 11, Case study 3, we also describe evidence of several practices used at Ashley Youth Detention Centre that involved separating children and young people from others, but which were not formally labelled as isolation or treated in line with legal requirements for the use of isolation. Labels used to describe such practices included ‘unit bound’, ‘individualised programs’, ‘separate routine’ and the ‘Blue Program’.

In that case study, we find that the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today. We also find that:

- Isolation practices often involved segregating children and young people from other detainees and denying them the right to take part in the usual educational programming offered through Ashley School.
- The Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action.
- The Department demonstrated, at best, naivety in repeatedly addressing poor and potentially unlawful isolation through training and policy change, and accepting lack of staff knowledge as an explanation, despite many staff, including operational leaders, having long employment histories at the Centre.

As noted in Section 4.7.2, in July 2023, Commissioner McLean informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, and that isolation practices continued to be used at the Centre.<sup>1275</sup> She advised that, over the previous six months, her office had observed (among other practices):

- Individual young people being referred to as ‘unit bound’ by staff during conversations, on office noticeboards, and in Weekly Review Meeting ... minutes;
- The extended use of unit-specific lockdowns ... and the extended isolation of individual young people, with one young person likening these practices to the ‘Blue Program’;
- Moving or threatening to move young people to units that experience more frequent lockdowns as a means of responding to and/or managing behaviour;
- The reintroduction of ‘quiet time,’ which sees young people restricted to their rooms every day between 12:30pm – 1:15pm, sometimes without staff being present in the unit ...<sup>1276</sup>

This is extremely concerning.

In response to Commissioner McLean’s comments, the Government acknowledged that restrictive practices continued at Ashley Youth Detention Centre due to staff shortages (discussed in Section 9.2.2).<sup>1277</sup> Secretary Bullard also stated:

The [Commissioner for Children and Young People] has expressed concern that young people at [Ashley Youth Detention Centre], particularly those in the Franklin Unit, have been locked down in response to their behaviour. I am advised that young people in the Franklin Unit have been subject to the same restrictive practices as other young people at [the Centre]. I understand that some residents may perceive that they are being treated differently if they are in their rooms while others are out of theirs. This is not the case, as restrictive practice means that young people are out of their rooms at different times of the day, depending on the number and experience of staff present in [the Centre] and the need to accommodate any association issues between young people.<sup>1278</sup>

We note that the Government’s response did not address Commissioner McLean’s observations:

- that staff were referring to individual children as ‘unit bound’
- of extended isolation of individual young people
- that daily 45-minute ‘quiet time’ had been reinstated.

As such, the Government’s response did not address all our grave concerns about the continuing use of isolation at Ashley Youth Detention Centre. As we only became aware of these concerns in July 2023, we were unable to continue to explore these specific matters.

Given the focus on isolation practices as human rights violations within our hearings—including a specific focus on ‘unit bound’ and the Blue Program—we find it astounding that these practices would persist or be reinstated during our Commission of Inquiry. Commissioner McLean’s observations suggest a culture that has continued to be punitive and has remained impervious to change. We remain gravely concerned that human rights abuses of children have occurred at Ashley Youth Detention Centre during our Inquiry and persist at the time of writing.

### 9.2.2 Lockdowns related to staff shortages

As discussed in Section 4.7, we also heard evidence about lockdowns involving children and young people being kept in their rooms for extended periods and unable to take part in normal programs, such as school, as a result of not enough staff being available to safely cover the normal operations of the Centre.<sup>1279</sup> We heard that, to ensure the Centre’s minimum staff-to-detainee ratios were maintained during staff shortages, only one child or young person per unit could be out of their room at a time, usually on an hourly rotation.<sup>1280</sup>

In November 2021, a young person detained at Ashley Youth Detention Centre made a complaint to the Ombudsman alleging they had been unable to attend school programs due to staff shortages.<sup>1281</sup> The Ombudsman’s investigating officer noted that it was concerning that a young person could not attend school programs for about a week due to the inability of staff to provide the necessary coverage, and the issue had not been proactively identified or addressed.<sup>1282</sup> We discuss restricted access to education during lockdowns in Section 6.6.2.

Commissioner McLean informed us that, between February and August 2022, her office had received 45 requests for advocacy about restrictive practices and lockdowns, making such practices the most common concern in the requests received during that time.<sup>1283</sup>

We also received concerning evidence from Vincenzo Caltabiano, former Director of Tasmania Legal Aid, and Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, that restrictive practices at Ashley Youth Detention Centre have had the effect of limiting children and young people’s access to legal representation.<sup>1284</sup>

Lucas Digney, Assistant State Secretary, Health and Community Services Union (Tasmania Branch), told us that the restrictive practices flowing from understaffing resulted in isolation of children and young people at Ashley Youth Detention Centre:

... they are being kept in their rooms for extended periods of time, and if one of our members wanted to place a young person in their room and they did it without authority, well, they would be disciplined for that because that young person is being isolated. And, I’m sure that most people would agree that that’s

an intolerable situation, that we are detaining young people and we're placing them in a regime of restrictive practice simply because we can't resource the facility where we're housing them.<sup>1285</sup>

Mark Morrissey, former Commissioner for Children and Young People, told us that isolation and lockdowns at Ashley Youth Detention Centre could be construed as constituting torture in the context of the United Nations' Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT'):

So, I understand within the OPCAT context ... the use of isolation to some people's minds would actually be a form of torture ... and we've heard evidence, I think, when I've been listening, of young people being locked in their cells for a week or two or longer alone, often on weekends due to staffing, short staffing, whatever reasons they were locked in their rooms as well. For a young person to be locked in a room, in my view, that does constitute a form of torture ...<sup>1286</sup>

In December 2022, the United Nations Committee against Torture (responsible for monitoring the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) stated that it was 'seriously concerned' about 'solitary confinement' practices at Ashley Youth Detention Centre and two other youth detention centres in Australia.<sup>1287</sup> The committee also stated that it considered current practices contravened the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the associated United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Nelson Mandela Rules).<sup>1288</sup>

In July 2023, the Commissioner for Children and Young People told us that 'rolling lockdowns' continued to occur at Ashley Youth Detention Centre.<sup>1289</sup>

### 9.2.3 The Department's views on lockdowns

In August 2022, Pamela Honan, Director, Strategic Youth Services in the Department, told us that the increased use of 'restrictive practices' was not satisfactory and that efforts had been made to communicate the context surrounding these restrictions to children and young people in detention:

I am not happy with staff having to implement restrictive practices, however, it has been explained to detainees that this is not their fault, and it is not a punishment. Staff on site are working with youth workers to ensure young people are rotated out of their rooms and units as much as possible to engage in educational learning, recreation activities and exercise. This occurs for several hours a day on most days but requires a number of staff to work significant overtime.<sup>1290</sup>

Secretary Pervan was asked whether he was aware of the opinion expressed by Mr Morrissey, and with which the Ombudsman agreed, that confining children to their rooms for prolonged periods could constitute torture.<sup>1291</sup> Secretary Pervan responded:

Without wanting to go to a specific case, only because I don't have the detail in front of me, as I understand—and it's a superficial understanding—the definition of 'torture' in that document goes to intent, and there was, I believe, looking at the past, a use of restrictive practice to—it would be argued by the staff involved it was used as a disciplinary measure, but yet the intent was to cause people to feel bad, it wasn't for their safety, it wasn't for any other purpose but to punish them.<sup>1292</sup>

Secretary Pervan distinguished between lockdowns caused by staff shortages and using isolation as torture:

There are two profound differences between isolation or restrictive practice being used as torture and what we've seen recently. One is that cognisance that it's damaging to the wellbeing of people to have them in isolation, and that in this instance when we haven't been able to get the young people out for the time that they've been required, the staff there, up to and including Ms Honan, have explained to them what the context is, why it's happening and what we're doing to try and fix it. So they haven't just been locked in their rooms and not told anything; it's been explained to them that its only because we're short of staff and we're doing everything we can to get them out of their rooms, and as soon as we've had more staff on deck they've been back to normal programs and access to services and activities.<sup>1293</sup>

Confining children and young people to their rooms for prolonged periods has serious detrimental effects on their health and wellbeing, regardless of the reason or justification for the confinement. Mr Watson told us that he is:

... very concerned when young people are restricted to their rooms due to staff shortages. I am concerned that their access to face-to-face schooling is reduced. I am concerned that their access to outside areas is reduced as well as their access to exercise, each other and their families is reduced. I am concerned that young people may have their mental health impacted.<sup>1294</sup>

#### **9.2.4 The Youth Justice Act and inspection standards**

As noted, isolation is defined in the Youth Justice Act as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'.<sup>1295</sup> The Youth Justice Act does not define 'normal routine' or 'separate from others'. As discussed in Chapter 11, Case study 3, Ashley Youth Detention Centre and the Department distinguished some practices, such as 'unit bound', from isolation under the Youth Justice Act on the basis that these practices were part of the normal routine of the Centre. We do not agree with this interpretation of the legislation.

Also as discussed in Chapter 11, Case study 3, Ashley Youth Detention Centre and the Department suggested that practices involving locking a young person in a unit with a youth worker did not constitute isolation under the Youth Justice Act on the basis that this is not separation 'from others'.<sup>1296</sup> We consider that the relevant question should be whether a child or young person has been separated from other children and young people, rather than from staff.<sup>1297</sup>

As outlined in Chapter 10, section 133 of the Youth Justice Act gives the detention centre manager the power to authorise the isolation of a child or young person:

- if their behaviour presents an immediate threat to their own safety or the safety of any other person or to property, and all other reasonable steps have been taken to prevent the child or young person from harming themselves, any other person or damaging property, but have been unsuccessful, or<sup>1298</sup>
- ‘in the interests of the security of the centre’ (this would appear to be the power generally relied on to authorise lockdowns of Ashley Youth Detention Centre).<sup>1299</sup>

The Youth Justice Act also provides that:

- If necessary, reasonable force may be used to place a child or young person in isolation.<sup>1300</sup>
- A child or young person in isolation must be ‘closely supervised and observed’ at intervals of no longer than 15 minutes.<sup>1301</sup>
- The detention centre manager must ensure the particulars of every use of isolation are recorded in an isolation register.<sup>1302</sup>
- Using isolation as a punishment is prohibited, ‘except as provided’ in section 133 of the Act.<sup>1303</sup>

The Inspection Standards refer to ‘separation, segregation or isolation’ but state that ‘isolation’ is ‘the term generally used by Ashley Youth Detention Centre and Children and Youth Services for instances of separation and segregation of young people’.<sup>1304</sup>

According to Standard 8.9:

- A young person should only be separated or segregated in response to an ‘unacceptable risk to themselves or others and only when all other means of control have been exhausted’ (although this standard contemplates that separation, segregation or isolation may also be necessary ‘for the good order of the detention centre’).<sup>1305</sup>
- Separation, segregation and isolation should never be used as a sanction or to obtain compliance with staff instructions.<sup>1306</sup>
- Separation, segregation or isolation should be for the minimum time necessary.<sup>1307</sup>
- Staff should closely supervise a child or young person in separation or segregation, who should not be left for long periods with nothing to occupy them.<sup>1308</sup>
- The conditions of separation or segregation should ‘provide no less amenity than normal accommodation’, except where a child or young person is separated due to a serious risk of suicide or self-harm.<sup>1309</sup>

- A register recording details of the separation and the young person’s routine while in separation should be maintained.<sup>1310</sup>

### 9.2.5 Custodial isolation procedures

The key policy and procedure document currently in place to guide the isolation of children and young people at Ashley Youth Detention Centre is the *Use of Isolation Procedure* dated 1 July 2017 (‘Isolation Procedure’).<sup>1311</sup> The Isolation Procedure defines ‘isolation’ in the same way as the Youth Justice Act, but specifies considerably more detailed requirements for using isolation than the Youth Justice Act and the Inspection Standards.<sup>1312</sup> As discussed in Chapter 11, Case study 3, staff at Ashley Youth Detention Centre do not appear to have applied the Isolation Procedure to some practices that involved the isolation of children and young people, such as ‘unit bound’.

According to the Isolation Procedure:

Isolation is a prohibited action, except for in very specific circumstances. All other reasonable steps must be taken before its use is considered. Where it is authorised it must be kept to the minimum time necessary to ensure the safety of individuals or property. The goal is to help the young person reintegrate into the group as safely and as quickly as possible.<sup>1313</sup>

The Isolation Procedure:

- requires youth workers to ‘make every effort’ to help a young person whose behaviour is escalating to regain control of their behaviour before resorting to isolation<sup>1314</sup>
- includes a (non-exhaustive) list of actions youth workers can take in response to a young person’s escalating behaviour—these include identifying and removing the trigger for the behaviour, redirecting the young person’s attention, offering a task such as exercising or listening to music, and asking another youth worker to take over supervision of the situation<sup>1315</sup>
- states that authorisation of isolation under the Youth Justice Act ‘in the interests of the security of the centre’ might include isolation ‘to prevent or control a security breach’ such as a riot, power failure, breach of the perimeter, or an escape, or ‘to allow order or control to be restored to the Centre (or to prevent its anticipated loss)’<sup>1316</sup>
- requires isolation to be authorised by the Centre Manager or their delegate (discussed below) in person, by phone or in writing<sup>1317</sup>
- states that, to authorise isolation, the Centre Manager (or their delegate) must be satisfied that ‘isolation is a reasonable intervention under the circumstances and is in accordance with the legislation and this procedure’<sup>1318</sup>
- prohibits the commencement of isolation until authorisation is obtained.<sup>1319</sup>



Before or as soon as possible after isolation has been authorised, the Centre Manager (or their delegate) must undertake an assessment to determine the conditions for the care and treatment of the young person while in isolation, in consultation with health services staff and members of Ashley Youth Detention Centre’s Multi-Disciplinary Team (discussed in Section 6.4.1) who are on site at the time.<sup>1320</sup> The assessment must consider matters such as the needs of the young person, any trauma history, their response to previous isolations, the risk of suicide or self-harm and their relationships with particular staff and other children and young people.<sup>1321</sup>

The Centre Manager (or their delegate) sets the conditions of isolation, which must be recorded on the authorisation form, in relation to:

- the period of isolation—this must be the shortest period that is appropriate in the circumstances and can involve an initial period of 30 minutes, an extension of the initial period to three hours and further extensions subject to an approval process (outlined below), but the total time in isolation cannot exceed 12 hours<sup>1322</sup>
- supervision and observation requirements—an observation must occur at least every 15 minutes and more often where there are concerns for the young person’s wellbeing, and observations must be recorded and signed by the observer<sup>1323</sup>
- medical reviews—a young person in isolation must be checked by the Correctional Primary Health Services nurse every three hours and by a medical practitioner after seven hours (or earlier on the advice of the nurse)<sup>1324</sup>
- ‘other conditions’—this may include specifying safe and therapeutic items to be left with the young person (such as playing cards or drawing materials) or access to a support person, cultural advisor or youth worker<sup>1325</sup>
- arrangements following the young person’s release from isolation—for example, whether they should be referred to ‘an appropriate health service’.<sup>1326</sup>

To extend isolation beyond a three-hour period, the Centre Manager (or their delegate) must:

- review the observation records prepared during the period of isolation
- consult with the Correctional Primary Health Services nurse or medical practitioner and available members of the Multi-Disciplinary Team
- consult with the Director, Strategic Youth Services on the outcome of these consultations
- complete the ‘Authorisation for Extension of Isolation’ form, noting any new conditions of the isolation or change to conditions.<sup>1327</sup>

As discussed in Chapter 11, Case study 3, in December 2021, the instrument dealing with delegation of authorities and powers at Ashley Youth Detention Centre was revised. The 2021 delegation instrument provides as follows:

- The Assistant Manager of the Centre may exercise the power to isolate a young person under the Youth Justice Act.<sup>1328</sup>
- The Director, Strategic Youth Services or the Operations Manager may exercise the power to isolate a young person under the Youth Justice Act if the Centre Manager and the Assistant Manager are ‘on leave, uncontactable, or unable for any other reason to perform the relevant function’.<sup>1329</sup>
- An Operations Coordinator may authorise isolation for a period of 30 minutes.<sup>1330</sup>
- A youth worker may exercise the power to isolate a young person under the Youth Justice Act, only for an initial period of 30 minutes and only if the youth worker is performing the duties of the Operations Coordinator.<sup>1331</sup>

The Centre Manager (or their delegate) must ensure ‘the particulars of every use of isolation’ are recorded in the isolation register.<sup>1332</sup> Since 2017, the isolation register has been recorded electronically.<sup>1333</sup> Each month, a report that includes the isolation register ‘and associated documents’ is sent to the Commissioner for Children and Young People and the Custodial Inspector.<sup>1334</sup> Commissioner McLean told us that:

... the quality and reliability of the [Ashley Youth Detention Centre isolation] data is questionable and there can be inconsistencies between the reports we receive from children and young people about the use of such practices, and the data.<sup>1335</sup>

In response to this comment, the Department told us that it was continuing ‘to look at the collection and reporting of data sets that relate to youth justice, with a view to improving both the integrity and timeliness of that data being reported’.<sup>1336</sup>

The Isolation Procedure requires the Centre Support Team (now known as ‘Weekly Review Meetings’—refer to the discussion in Section 6.4.1) to conduct monthly reviews of the use of isolation. These reviews must focus on any patterns of use, any strategies that have been useful in reducing isolation use or reducing the length of time someone is in isolation, and how that information can be used to inform staff training, supervision and program scheduling.<sup>1337</sup> The Centre Support Team must forward this information to the Centre Manager (if they were not at the meeting) and the Director, Strategic Youth Services.<sup>1338</sup>

Secretary Pervan told us that isolations data is analysed monthly for the Director and that ‘if a pattern is identified’ for a particular young person or staff member, ‘the Director will ask the Manager, Custodial Youth Justice for more information to determine whether there is an issue with the young person or staff member’.<sup>1339</sup> Secretary Pervan also told us that the Commissioner for Children and Young People is provided with copies of minutes from Weekly Review Meetings and with monthly isolation summaries.<sup>1340</sup>

The Isolation Procedure states that the Quality Improvement and Workforce Development Team randomly selects incidents that involved isolation to assess whether isolation was appropriately authorised, observations were carried out appropriately, the period of isolation was appropriate, and if isolation use was accurately recorded in the isolation register.<sup>1341</sup> This team no longer exists, so this safeguard is now missing.

Secretary Pervan also told us that, following an isolation, an evaluation of the isolation episode is conducted at the next meeting of the Multi-Disciplinary Team.<sup>1342</sup>

## 9.2.6 Our recommendations on isolation and lockdowns

### Definition of isolation and amendments to the Youth Justice Act

We consider that any practice involving a child or young person in detention being confined to their room or unit and prevented from having contact with other children and young people (outside the normal overnight routine) constitutes isolation and should be managed in accordance with the law, standards and procedural requirements for isolation, regardless of the label used to refer to the practice. In particular, a practice should be considered isolation even if a child or young person is confined to a unit with a member of staff. This should be made clear in the Youth Justice Act. This change should ensure all isolation practices (broadly defined) are authorised and recorded according to the appropriate procedure.

Isolation must not be used as punishment for perceived poor behaviour. As discussed in Chapter 11, Case study 3, many instances of isolation of children and young people at Ashley Youth Detention Centre were connected to the Behaviour Development System (later renamed the Behaviour Development Program) and were, ultimately, used as a form of punishment for perceived inappropriate or poor behaviour. In Section 6.3.4, we recommend that the Behaviour Development Program be discontinued.

The list of ‘prohibited actions’ in the Youth Justice Act refers to ‘the use of isolation, within the meaning of section 133, as a punishment except as provided in that section’.<sup>1343</sup> In our view, as currently worded, this provision can be read as allowing isolation as a punishment where it is carried out in line with section 133. This can be contrasted with the equivalent Victorian provision in the *Children, Youth and Families Act 2005 (Vic)*, which simply lists as a prohibited action ‘the use of isolation (within the meaning of section 488) as a punishment’.<sup>1344</sup> We recommend that the Youth Justice Act be amended to state more clearly that isolation must not be used to punish a child or young person.

We note that, in New South Wales, the *Children (Detention Centre) Act 1987 (NSW)* makes it a criminal offence for a person to punish a detainee or cause a detainee to be punished by ‘segregating’ them in contravention of section 19 of that Act.<sup>1345</sup> We recommend that the use of isolation as a punishment be made a criminal offence in Tasmania.

We also recommend that the Youth Justice Act explicitly refers to the principle that isolation should only be used as a measure of last resort and for the minimum time necessary.

### **Changes to the Isolation Procedure**

We recommend that the Department clarifies delegations for the purposes of authorising isolation and extensions of isolation, and that these delegations be specified in the Isolation Procedure. In particular, the circumstances in which the Centre Manager or Assistant Manager are ‘uncontactable, or unable for any other reason to perform the relevant function’ should be clarified, so all staff and managers of detention facilities and others in the Department have a clear understanding of authorisation processes for isolation. As described in Chapter 11, Case study 3, the need to clarify this was highlighted by the independent investigation of an incident that occurred at Ashley Youth Detention Centre in December 2019 involving the isolation of children and young people at the Centre.

We also recommend that the Department alters the Isolation Procedure to require authorisation to extend a period of isolation beyond three hours to be provided by a senior departmental official, rather than by the Centre Manager. We consider such oversight to be necessary given the serious and detrimental effects of extended isolation on children and young people’s mental health and wellbeing.

We also recommend that the Department publishes the Isolation Procedure on its website.

### **Staff understanding and implementation of isolation procedures**

As discussed in Chapter 11, Case study 3, we are concerned about inconsistencies in Ashley Youth Detention Centre staff and managers’ understanding of isolation procedures, particularly in relation to which circumstances amounted to isolation and the authorisation processes when the practice was identified as isolation.

It is vital that departmental and detention centre managers and staff understand what practices amount to isolation and the procedures for authorising and implementing lawful and appropriate isolation of children and young people.

It is also important to ensure isolation is not being used as a primary or default response to children and young people who display difficult, challenging or complex behaviour, or as a punishment for negative behaviour. The Draft Youth Justice Blueprint refers to the fact that the best-performing youth justice systems achieve safety and security ‘primarily through relationships’ rather than isolation.<sup>1346</sup> This requires, at a minimum, comprehensive, ongoing training and professional development for operational staff in de-escalation techniques and the appropriate use of isolation. Our recommendation for training on the use of isolation is discussed in Section 9.4.

However, we also consider that cultural change may be required to ensure staff comply with isolation laws and procedures in detention. As discussed in Chapter 11, Case study 3, we hold concerns that a punitive culture may have been supported and applied by some staff at Ashley Youth Detention Centre, who may have taken opportunities, whenever they arose, to nullify reforms to isolation procedures and return to more punitive isolation practices.

In Section 4.2, we discuss resistance to change among some staff at Ashley Youth Detention Centre. To address this issue and achieve meaningful cultural change in youth detention, in Section 4, we recommend significant reforms in the areas of staffing, leadership, governance and children's participation.

### **Changes to reporting and oversight**

We consider that there needs to be greater Department oversight of isolation in detention. As discussed in Chapter 11, Case study 3, it is not clear that the Centre Manager routinely reported all uses of isolation to the Department, as opposed to doing so only in instances where isolation formed part of a response to a critical incident on site. Secretary Pervan told us that '[t]he Director is informed contemporaneously with any periods of isolation that extend beyond three hours', but this is not reflected in the Isolation Procedure.<sup>1347</sup> Updating the Isolation Procedure to require authorisation for isolation longer than three hours from a senior departmental official (as recommended) will improve departmental oversight of isolation.

The Isolation Procedure refers to monthly reviews of isolations at Ashley Youth Detention Centre being provided to the Director, and regular audits of isolations being undertaken by the Department's Quality Improvement and Workforce Development Team. As mentioned in Section 9.2.5, this team no longer exists and we are not aware that its functions for monitoring isolations are currently performed by any other team in the Department.<sup>1348</sup>

The Department should provide monthly reports on isolation to the Secretary. This is important for effective internal oversight of youth detention, particularly given the previous lack of transparent reporting from Ashley Youth Detention Centre to senior officials in the Department.

The Department should not rely solely on Ashley Youth Detention Centre's analysis of isolations data. As with searches, we recommend quarterly reporting on isolations to the new Quality and Risk Committee, which should monitor trends and patterns in isolation use and identify any areas of concern.

We also recommend, at a minimum, monthly reporting of isolation data—including the register and all relevant supporting documentation—to the new Commission for Children and Young People (Recommendation 18.6). In response to a draft of this chapter, Commissioner McLean proposed that the Department be required to report isolations

to the Commission for Children and Young People within 24 or 48 hours of each isolation incident.<sup>1349</sup> We have not tested the feasibility of this proposal with the Government. The Government should work with the Commission for Children and Young People to determine an appropriate regime for the reporting of isolation data that prioritises the safety of children and young people.

In addition, to acknowledge the importance of these issues and to strengthen transparency and accountability, we recommend that the Department publishes quarterly data about isolation in youth detention.

### **Changes to address lockdowns**

We acknowledge that, even in a well-run detention facility, occasional lockdowns may be unavoidable. However, we are deeply concerned about the prolonged, rolling lockdowns that have occurred at Ashley Youth Detention Centre in recent years due to chronic understaffing and the seriously detrimental impact of these lockdowns on the mental and physical wellbeing of children and young people in detention. We understand that, as recently as July 2023, lockdowns brought on by staff shortages continued at the Centre, with children and young people locked in their rooms or units for up to 23 hours a day.<sup>1350</sup>

We acknowledge that there was no suggestion made to us by the Department or Ashley Youth Detention Centre management or staff that lockdowns were beneficial or did not present a significant cause for concern. We also acknowledge that, to some degree, especially in relation to the COVID-19 pandemic, understaffing has been beyond the direct control of the Centre's management and the Department. However, as discussed in Section 4.7.2, while sometimes framed by management and departmental officials as a recent phenomenon, staff shortages have been a longstanding issue at Ashley Youth Detention Centre.

As discussed in Section 4.2.2, understaffing damages staff morale, increases workloads and creates risks to staff safety. Lockdowns imposed when there are not enough staff can make children and young people 'agitated and more difficult to engage with' when they are released from their rooms, which 'leads to frustration and confrontation between staff and detainees'.<sup>1351</sup> This can, in turn, lead to further reductions in staff numbers, creating a cycle that is difficult to break.

The persistent nature of staff shortages at Ashley Youth Detention Centre requires the Department to take steps to ensure the Centre is appropriately staffed to provide therapeutic responses to children and young people and avoid the need for lockdowns. We make recommendations to improve staff recruitment and retention in Section 4.7.3. We anticipate that implementation of these recommendations will reduce the need for lockdowns.

We understand that the power to authorise a lockdown of a youth detention facility arises from the power in the Youth Justice Act to authorise isolation of a child or young person ‘in the interests of the security of the centre’.<sup>1352</sup> Isolation under this provision is covered by the Isolation Procedure, although the relevant part of the procedure does not refer to lockdowns.

We made a number of requests for information about the policies and processes under which children and young people in detention are isolated and how the use of isolation is monitored.<sup>1353</sup> Although we did not receive evidence on the process for authorising lockdowns at Ashley Youth Detention Centre, it was not clear to us that the Isolation Procedure was followed. That procedure would require individual assessments to be undertaken for every child or young person to be subjected to a lockdown before it could be authorised, with individual plans for how each child or young person’s isolation during the lockdown should be managed. It would also require the isolation of each child and young person as part of a lockdown to be entered on the isolation register.

While we acknowledge that the Isolation Procedure focuses primarily on ‘behavioural’ isolations, and does not appear to contemplate facility-wide lockdowns, it is concerning if proper procedures are not being followed for the isolation of children and young people through lockdowns. In recognition of the serious impact of lockdowns on children and young people in detention, we recommend that Ashley Youth Detention Centre (and any future detention facility) records information about lockdowns, including unit-specific lockdowns, separately from isolations occurring in response to behaviour. This should include the reason for the lockdown, the number of children and young people subjected to the lockdown, the duration of the lockdown and the measures taken to meet children’s and young people’s needs, and support their health and wellbeing during the lockdown.

Lockdown data should be provided to the new Commission for Children and Young People (Recommendation 18.6), monthly or more frequently, and be published regularly on the Department’s website. We note that, in Victoria, the Department of Justice and Community Safety publishes quarterly data on ‘behavioural based’ isolations and ‘isolations based on the security of the centre concerns’ (lockdowns) in youth justice centres.<sup>1354</sup>



## Recommendation 12.32

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act:
  - a. makes clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice
  - b. clarifies that the use of isolation as a punishment is a prohibited action and makes it a criminal offence for a person to punish a detainee by isolating them or causing them to be isolated
  - c. refers expressly to the principle that isolation should only be used as a measure of last resort and for the minimum time necessary.
2. The Department for Education, Children and Young People should:
  - a. update the Department's *Use of Isolation* procedure to
    - i. make clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice
    - ii. specify clearly who is a delegate of the Secretary or the detention centre manager for the purpose of authorising isolation and extensions of isolation
    - iii. require isolation beyond three hours to be authorised by a senior departmental official such as a Director
    - iv. specify internal and external reporting requirements in relation to isolation
  - b. publish the updated *Use of Isolation* procedure on the Department's website
  - c. ensure Ashley Youth Detention Centre (and any future detention facility) records information on lockdowns, including the reason for the lockdown, details of authorisation processes, the duration of the lockdown, the number of children and young people isolated during the lockdown, measures adopted during the lockdown to meet the needs of children and young people and support their health and wellbeing, and steps taken after the lockdown to address its effects on children and young people

- d. ensure Ashley Youth Detention Centre (and any future detention facility) provides
  - i. monthly reports on isolation and lockdowns in detention to the Secretary
  - ii. quarterly reports on the isolation of children and young people in detention and lockdowns to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
  - iii. the isolation register (with all relevant supporting documentation) and separate data on lockdowns to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People
- e. publish quarterly data on isolation and lockdowns in youth detention.

## 9.3 Use of force

As outlined in Chapter 10, according to international legal instruments, the use of force in detention is only permitted when it is strictly necessary—that is, where the child poses an imminent threat of injury to themselves or others—and where other methods of control have been exhausted.<sup>1355</sup> When force is deemed necessary, it must be used: by properly trained staff; for the shortest possible time or a limited time; without causing humiliation and degradation; and only in self-defence, in response to attempted escape or in response to active or passive physical resistance.<sup>1356</sup>

### 9.3.1 What we heard about the use of force in detention

As discussed in Chapter 11, Case studies 1 and 4, we heard evidence about some staff regularly using force against children and young people at Ashley Youth Detention Centre. Some of the experiences shared by victim-survivors about the use of force included:

- force and restraints being used to effect strip searches
- children and young people being restrained as part of isolation practices
- force, restraints and violence being used to punish children and young people for not following orders or for reporting abuse
- staff using violence against children and young people, and encouraging violence amongst them, as a form of humiliation
- force, restraints and violence being used to facilitate staff members' sexual abuse of children or young people, or in connection with sexual abuse.

As detailed in Chapter 11, Case studies 1 and 4, we heard allegations that children and young people detained at Ashley Youth Detention Centre had been pinned down by staff members for relatively minor infractions, had their heads deliberately slammed against furniture and walls, been handcuffed for hours at a time, been dragged while handcuffed, had bones broken by staff, and had staff target them for physical violence. We discuss the punitive culture at Ashley Youth Detention Centre in Section 4.2.

In Chapter 11, Case study 4, we find that:

- Most, if not all, the accounts we heard describe an excessive, unreasonable or likely illegal use of force by some staff at Ashley Youth Detention Centre.
- Victim-survivors' accounts, viewed as a whole, suggested a pattern of some staff using force instead of de-escalation techniques to manage young people's behaviour.
- Various reviews of inappropriate uses of force at Ashley Youth Detention Centre from 2016 to 2017 identified that force was used other than as a last resort or when there were no obvious threats to staff or others.
- The excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately.

Commissioner McLean told us that children and young people in custody consistently raise concerns with her regarding the excessive use of force and that:

use of force incidents against children and placing the child in isolation are closely interrelated, often causally and cyclically: an isolation event leading to behaviour of a child where force is used, causing further isolation, and so on.<sup>1357</sup>

At our hearings in August 2022, Mr Watson indicated that he believed that the use of force had decreased recently due to increased closed-circuit television camera coverage and hard drive capacity to store the footage, but conceded that force was still used too often:

My Director's Executive Assistant has been in her role for 25 years and I can recall her saying to me on two months in a row, this is the first time in her 25 years that she can recollect no use of force and no isolation for the centre ... That's something that, you know, when I first started, use of force and isolation were reasonably common and it's something that I'm—I believe is far less common today; however, it's still too high. We're still working to reduce it further.<sup>1358</sup>

We discuss the limited coverage of closed-circuit television cameras at Ashley Youth Detention Centre in Section 6.2.

### 9.3.2 The Youth Justice Act and inspection standards

As outlined in Chapter 10, the Youth Justice Act prohibits the use of physical force against a child or young person unless it is reasonable and:

- necessary to prevent the child or young person from harming themselves or anyone else, or from damaging property
- necessary for the security of the centre, or
- otherwise authorised under the Youth Justice Act or at common law—reasonable force may be used to carry out a search or to place a child or young person in isolation.<sup>1359</sup>

The Youth Justice Act also prohibits any action that inflicts, or is intended to inflict, physical pain or discomfort on a child or young person in detention as a punishment.<sup>1360</sup>

If force is used in the context of a search, this must be reported to the person in charge of the facility.<sup>1361</sup>

The Inspection Standards set a higher standard than the Youth Justice Act for when force can be used and the conditions of its use. The standards state that force must only be used ‘when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted’.<sup>1362</sup>

The Inspection Standards also state that:

- force must only be used for ‘the shortest time required’<sup>1363</sup>
- force should never be used as a sanction or to obtain a young person’s compliance with staff instructions<sup>1364</sup>
- the use of force should not cause humiliation or degradation<sup>1365</sup>
- all instances of force should be recorded, investigated and reported<sup>1366</sup>
- a young person who has been subjected to force should be provided with health care following the incident and offered the opportunity to discuss the incident with a staff member who was not involved<sup>1367</sup>
- parents and carers are notified of incidents of restraint or force where appropriate.<sup>1368</sup>

### 9.3.3 Custodial procedures on the use of force

The key policies and procedures on the use of force at Ashley Youth Detention Centre are the:

- *Use of Physical Force Procedure* dated 10 December 2018 (‘Use of Force Procedure’)<sup>1369</sup>

- *Minimising the Use of Physical Force and Restraint Practice Advice* dated 1 July 2017 ('Use of Force Practice Advice')<sup>1370</sup>
- *Use of Mechanical Restraints (Handcuffs) Procedure* dated 21 October 2019<sup>1371</sup>
- *Use of Mechanical Restraints Practice Advice* dated 21 October 2019.<sup>1372</sup>

Together, these documents prohibit:

- using 'excessive force', which is defined to include 'any force when none is needed', 'more force than is needed', 'any force or level of force continuing after the necessity for it has ended', and 'knowingly wrongful use of force'<sup>1373</sup>
- using a technique or hold 'that is not proportionate to the level of risk present' or for longer than required, use of positions that make it difficult for the young person to breathe, and use of body weight to sit or lie across a young person's back or stomach<sup>1374</sup>
- applying direct pressure to the neck, thorax, abdomen, back or pelvic area<sup>1375</sup>
- using handcuffs except where 'it is reasonable and necessary to prevent harm to a person, property or for the security of the Centre and all other means of control have been exhausted and failed' (handcuffs 'must never be used as a punishment')<sup>1376</sup>
- using any type of mechanical restraint other than handcuffs<sup>1377</sup>
- using force against a young person to facilitate compliance with an order or direction from a staff member.<sup>1378</sup>

The Use of Force Procedure advises staff that, where excessive use of force is suspected, they may be subject to 'internal and/or external investigation' and 'disciplinary and/or criminal proceedings'.<sup>1379</sup>

According to the Use of Force Practice Advice, '[t]he use of force is considered a severe measure that should only be carried out as a last resort'.<sup>1380</sup> If a young person appears unsettled or anxious, or if an incident is escalating, the Use of Force Procedure requires staff to 'alert the Operations Coordinator and other relevant staff' to discuss and assess the level of risk, and strategies to reduce the chance of an incident occurring or escalating.<sup>1381</sup> When undertaking a risk assessment, staff are encouraged to consider matters such as what is going on in the young person's life as well as the young person's developmental age, mental or physical traits, substance use, history of incidents and previous reactions to the use of force.<sup>1382</sup>

The Use of Force Practice Advice emphasises the importance of communicating with the young person, using non-threatening body language, listening, asking open-ended questions, guiding them towards making positive behaviour choices and being 'specific and gentle, but firmly directive' about the desired behaviour.<sup>1383</sup>

To assess whether force is an appropriate response, staff must consider whether it is ‘proportionate’, ‘lawful’, ‘accountable’ (staff must be able to justify using force and explain why other options were not used), ‘necessary’ (the force must be required to fulfil a staff member’s duty of care), and ‘ethical’ (the use of force must ‘reflect human rights principles’).<sup>1384</sup>

When force is required, staff must:

- ‘apply the minimum amount of physical force necessary using an approved technique to gain control of the young person’s behaviour’<sup>1385</sup>
- continuously monitor the young person for signs of distress and continue talking to the young person throughout the incident, making it clear that the use of force will stop when it is no longer necessary to protect the young person or others<sup>1386</sup>
- ‘discontinue the use of force as soon as the young person has become compliant’.<sup>1387</sup>

Following a use of force, the Operations Manager must review closed-circuit television camera footage of the incident as soon as practicable and the Operations Coordinator must:<sup>1388</sup>

- report the use of force to the Centre Manager<sup>1389</sup>
- put in place a plan to debrief the young person if required, review the young person’s ‘behaviour goals and strategies’ and address the need for any ‘post incident intervention’<sup>1390</sup>
- ensure any injured staff have been attended to and ‘conduct a debrief for all staff involved in the incident to ensure they are safe and well before they go home’.<sup>1391</sup>

The Correctional Primary Health Services nurse must ‘sight every young person who has been restrained, assess for possible injury and treat as required’.<sup>1392</sup>

Relevant staff must record the details of the use of force on the ‘Use of Force Register’ and ‘follow the Incident Reporting procedure’.<sup>1393</sup> We understand this to be a reference to the *AYDC Incident Reporting Procedure* dated 1 July 2018 (‘Incident Reporting Procedure’).<sup>1394</sup> The purpose of that procedure is to ‘outline the steps that staff at Ashley Youth Detention Centre must take following an incident that has arisen from the behavior/s of a young person or multiple young people’.<sup>1395</sup> The Incident Reporting Procedure does not define ‘incident’.

According to the Incident Reporting Procedure:

- Staff must report information about the incident and the young person—this includes identifying ‘whether restrictive practices were used and what type (use of force, mechanical restraints, isolation)’ and recommending ‘a level of seriousness (recorded incident, minor incident or detention offence)’ for the incident.<sup>1396</sup>

- The Centre Support Team (now known as ‘Weekly Review Meetings’) must review the circumstances of the incident.<sup>1397</sup>
- The Centre Manager must review the incident, decide on further actions required and advise the Director, Strategic Youth Services ‘as appropriate’—if notified, the Director must decide whether an independent investigation is called for and the type of investigation.<sup>1398</sup>

Ms Honan told us that incident reporting is escalated to her ‘if there is a significant event such as sexual/physical assault, damage to property, disturbance, self harm, [or] escape’ and that she is notified of ‘[a]ll incidents of injury or harm to a young person’.<sup>1399</sup> This list would not cover all uses of force. Ms Honan also told us that, in 2020, the ‘Ashley Incident Management System’—a centralised system for electronic recording of incidents—was implemented and all staff were trained in using this system.<sup>1400</sup>

The Use of Force Procedure requires the Centre Support Team to conduct monthly reviews on the use of force and to forward this information to the Centre Manager and the Department.<sup>1401</sup> Ms Honan told us she receives monthly reports on the use of force.<sup>1402</sup>

The Use of Force Procedure also contemplates the review of an agreed number of randomly selected incident reports involving the use of force to establish whether force was appropriate and accurately recorded in the use of force register, but does not specify who should conduct these reviews or how often they should be conducted.<sup>1403</sup>

### 9.3.4 Recent reforms

The Keeping Kids Safe Plan refers to the Department establishing an ‘Incident Review Committee’ at Ashley Youth Detention Centre, in September 2022, to ‘review incidents on a weekly basis for compliance with policy and procedure, follow up actions based on review findings and to identify learning areas to support staff’.<sup>1404</sup> This committee is chaired by the Director, Custodial Operations, and its members include the Director, Strategic Youth Services and the Centre Manager.<sup>1405</sup> The committee reports to the Executive Director, Services for Youth Justice.<sup>1406</sup>

According to the Incident Review Committee’s terms of reference, its functions are to review ‘all serious/major incidents that occurred over the last 7 calendar days’ and ‘agree actions to be undertaken or make recommendations arising from the serious/major incident’.<sup>1407</sup> The terms of reference anticipate that ‘relevant footage will be downloaded, reviewed and discussed by the committee members during the meeting’.<sup>1408</sup>

We are unsure how the work of the Incident Review Committee intersects with or complements the work of the Risk Assessment Process Team, which also reviews serious incidents (refer to Chapter 10).



Further, the division of responsibility between the Incident Review Committee and the Weekly Review Meetings in reviewing incidents weekly at Ashley Youth Detention Centre is unclear to us. It may be that the Incident Review Committee is responsible for reviewing only ‘serious/major’ incidents, while all other incidents are considered at the Weekly Review Meetings. It would be beneficial to clarify this in the Incident Reporting Procedure.

The Keeping Kids Safe Plan also states that Ashley Youth Detention Centre ‘reports all critical incidents and follow up actions to both the [Commissioner for Children and Young People] and Custodial Inspector on a real time basis’.<sup>1409</sup> However, Commissioner McLean told us that she does ‘not receive reports of all critical incidents’ at Ashley Youth Detention Centre and that, when she is notified of incidents, it is ‘certainly ... not in “real time”’.<sup>1410</sup> She also stated that she is ‘not generally provided with sufficient detail to understand what has occurred and what has been done in response to the incident’.<sup>1411</sup>

### 9.3.5 Minimising the use of force in detention

The Inspection Standards impose a more stringent standard than the Youth Justice Act for the use of force in detention by not permitting force solely to prevent damage to property or where ‘necessary for the security of the centre’.<sup>1412</sup>

We recommend amendments to the Youth Justice Act to more closely reflect the Inspection Standards. In particular, the Youth Justice Act should provide that force should only be used against a child or young person in detention when reasonable and necessary to prevent an imminent and serious threat of harm to the child or young person or to others, or to prevent an imminent escape, and when all other means of control have been exhausted. Force should be used for the shortest time necessary and should never be used to punish a child or young person or to secure their compliance with an instruction or direction. We consider that these changes would enable the use of force to prevent an assault, harmful sexual behaviours or the destruction of property that involves an imminent threat of serious harm to a person.

We do not recommend any changes to the existing provisions of the Youth Justice Act in relation to the use of force to carry out a search or to place a child or young person in isolation, noting we make recommendations in Section 9.2.6 directed at minimising the use of isolation.

We also recommend that the Youth Justice Act makes it a criminal offence for a person to use force against a child or young person in detention in contravention of the Act. We note that section 22 of the *Children (Detention Centres) Act 1987* (NSW) makes it a criminal offence to subject a detainee to a range of punishments, including striking them or subjecting them to any other form of physical violence, or to handcuff or forcibly restrain a detainee without reasonable excuse.<sup>1413</sup>

The Use of Force Procedure is considerably more comprehensive than the Youth Justice Act in terms of controls, checks and balances on the use of force. However, we consider that it could be strengthened to reflect extra safeguards in the Inspection Standards, namely:

- the requirement to provide every child or young person who has been subjected to force with health care (as opposed to the current requirement for the nurse to 'sight every young person who has been restrained')<sup>1414</sup>
- the requirement to offer every child or young person who has been subjected to force the opportunity to discuss it with a staff member who was not involved (as opposed to the current requirement to '[d]ebrief the young person ... if required')<sup>1415</sup>
- the requirement to notify parents and carers of incidents of force or restraint where appropriate.

We also recommend that the Use of Force Procedure be updated to require all uses of force to be reported immediately to a senior departmental official such as a Director.

Consistent with our recommended approach to reporting on searches, isolation and lockdowns, we recommend monthly reporting on the use of force to the Secretary, and quarterly reporting to the Quality and Risk Committee to monitor trends and patterns in the use of force.

Data on the use of force should also be reported to the new Commission for Children and Young People (Recommendation 18.6). The Commissioner for Children and Young People proposed that such reporting occur within 24 or 48 hours of each use of force incident.<sup>1416</sup> However, we have not tested the feasibility of this proposal with the Government. We recommend monthly reporting, at a minimum, on the use of force to the new Commission. The Government should work with the Commission for Children and Young People to determine an appropriate frequency for the reporting of data on the use of force in youth detention.

Finally, we are concerned that incidents examined in Chapter 11, Case study 4, reveal that staff did not follow procedure. We address this in the next section.

## Recommendation 12.33

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

## 9.4 Training on searches, isolation and use of force

In Section 4.7.3, we recommend continuing professional development for youth workers on: expected standards of behaviour in interacting with children and young people; the human rights of children and young people in detention; approaches to setting fair, clear and firm boundaries for children and young people's behaviour within a therapeutic, trauma-informed framework; and training in all custodial policies and procedures.

As noted throughout this section, there is a particular need for ongoing training and professional development for youth detention centre staff in laws, policies and procedures on searches, isolation and the use of force. We consider that it is also important for staff of the Department's Youth Justice Services directorate (including leadership) who are not based at Ashley Youth Detention Centre to be familiar with the laws, policies and procedures for these practices. This would ensure consistency of understanding across the Department, strengthen internal oversight of restrictive practices in detention and improve those practices.

Accordingly, we recommend joint training for staff of youth detention facilities and other relevant youth justice staff in the Department on the laws, standards, policies and procedures on isolation, the use of force and personal searches of children and young people in detention. While we consider that such training will help change practices at Ashley Youth Detention Centre, training alone is not enough. In Section 4, we make recommendations designed to achieve broader cultural change in youth detention and ensure past harmful practices do not continue.

There is also a need to ensure police understand legislative and procedural requirements for restrictive practices in youth detention. In Chapter 11, Case study 7, we find that Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre. Our suggestions for improvement include ensuring police have ready access to guidance on Tasmanian law in relation to personal searches, isolation and the use of force so they can readily identify when alleged conduct falls outside the parameters of acceptable professional conduct and may indicate that a crime has occurred. We make a recommendation to this effect here. We consider that this guidance will also assist police who carry out searches of children and young people in police custody.

## Recommendation 12.34

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

# 10 Responding to concerns, complaints and critical incidents in youth detention

Effective complaints processes are critical to creating a safe detention environment. Children and young people in detention who have a concern—for example, about the services they have received or not received while in detention, or about the behaviour of staff or other children and young people, including child sexual abuse—need a clear, safe and accessible process to raise the concern and make a complaint, and to have confidence that it will be taken seriously and responded to appropriately. Effective processes are also required for the family members of children and young people in detention or detention facility staff who want to raise a concern about the treatment or safety of a child or young person in detention.

Complaints from or about a child or young person in detention can be responded to ‘internally’ (by the detention facility or by the Department) or ‘externally’ (by an independent oversight body). In Section 11, we discuss the role of external oversight bodies in supporting children and young people in detention to raise concerns about their treatment (including making a formal complaint about the Department to the Ombudsman) and advocating to resolve their concerns.

In this section, we examine the internal processes of Ashley Youth Detention Centre and the Department for identifying and responding to concerns and complaints from or about children and young people in detention, including those involving child sexual abuse and other serious allegations.

The case studies in this volume indicate serious problems with the Department's responses to concerns, complaints and critical incidents in detention involving risks to the safety of children and young people in detention. In Chapter 11, Case study 2, we find that Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these behaviours. As discussed in that case study, when harmful sexual behaviours occurred, staff or Centre management often failed to respond appropriately—whether by not removing the risks, not supporting the victim-survivor, or punishing them for making a complaint.

In Chapter 11, Case study 6, we find that Ashley Youth Detention Centre and the Department did not respond appropriately to a serious allegation from Max (a pseudonym) of misconduct against a staff member. As discussed in that case study, we consider that the response to Max's allegation suggests systemic problems in how Ashley Youth Detention Centre and the Department respond to serious allegations, including by children and young people against staff members. We observed similar problems in the Department's response to allegations of child sexual abuse against staff (discussed in Chapter 11, Case study 7) and in a complaint from Alysha (a pseudonym), a former staff member at Ashley Youth Detention Centre, about the safety of children (discussed in Chapter 11, Case study 5).

Overall, the evidence detailed in our case studies indicates shortcomings in the Department's responses to complaints, including not:

- creating a culture where complaints by staff or children and young people are encouraged
- recognising complaints involving child sexual abuse or harmful sexual behaviours
- appropriately escalating and formalising complaints
- adequately and appropriately investigating complaints
- responding to complaints in a way that maintained safety and confidentiality and managed fear of reprisal for the complainant
- addressing safety risks raised by complaints.

The National Royal Commission recommended that institutions have 'a clear, accessible and child-focused complaints handling policy and procedure that sets out how the institution should respond to complaints of child sexual abuse'.<sup>1417</sup> The National Royal Commission's final report set out a list of actions that should form part of an effective institutional response to a complaint of child sexual abuse. These were: identifying a complaint; assessing risk; reporting to police, child protection and other bodies; investigating the complaint; communicating and providing support to those affected

by the complaint; maintaining records; completing a ‘root cause analysis’ to identify systemic factors that may have contributed to the complaint; and monitoring and reviewing outcomes.<sup>1418</sup>

The National Royal Commission also recommended that state and territory governments review internal and external complaints-handling systems concerning youth detention to ensure they are capable of effectively dealing with complaints of child sexual abuse.<sup>1419</sup> According to this recommendation, the review should ensure (among other matters) that children can easily access child-appropriate information about complaints processes, complaints-handling systems are accessible for children with literacy difficulties or who speak English as a second language, and children are regularly consulted about the effectiveness of complaints-handling systems, so systems are continually improved.<sup>1420</sup>

In our view, the Department’s processes for identifying and responding to complaints and serious incidents in youth detention, including those relating to child sexual abuse, require significant reform. In this section, we recommend that the Department implements measures to:

- address structural barriers in complaints systems and create a culture in which complaints and critical feedback from staff, children and young people in detention and family members are encouraged (broader cultural change in youth detention is discussed in Section 4)
- provide for concerns and complaints about child sexual abuse and related conduct by staff to be referred to and investigated by a new Child-Related Incident Management Directorate, recommended in Chapter 6 (Recommendation 6.6)
- ensure concerns and complaints related to harmful sexual behaviours are reported to the Department’s new Harmful Sexual Behaviours Support Unit and managed in line with a separate policy recommended in Section 8.5 of this chapter (Recommendation 12.30)
- ensure children and young people in detention feel safe to raise concerns, are aware of their rights to make a complaint and understand complaints processes
- ensure staff are aware of their role in responding to concerns raised by children and young people in detention and have clear processes for raising concerns about other staff
- update and strengthen custodial policies and procedures for complaints processes.



## 10.1 What we heard about complaints processes in detention

Victim-survivors told us about their experiences in making, or attempting to make, complaints at Ashley Youth Detention Centre. They reported significant barriers to making complaints. Some said that they did not complain for fear of repercussions from staff or other detainees; others told us they tried to complain but felt discouraged from going further because of the responses they received.<sup>1421</sup> We acknowledge that the complaints policies and procedures in place at the time of these experiences differed from those currently in place (described in Section 10.2); however, we consider that this evidence is still highly relevant to reforming complaints handling for children and young people in detention.

One victim-survivor, Fred (a pseudonym), said he received no feedback at all after making a complaint:

So, I wrote down my experience on a piece of paper and put it in an envelope with – I believe I was told to put ‘complaints’ on it – and slipped it under my door; it was picked up by passing officers, like, as all mail would go out, and I never heard anything. I put two complaints in in my time at Ashley and I never heard anything about either of them.<sup>1422</sup>

Victim-survivor Warren (a pseudonym) described never making a complaint due to fear of the repercussions:

I never made a complaint about anything that happened while I was in Ashley. The process of making a complaint was to write it down and give it to the workers. If someone ever complained about something it would always get back to the workers and they would tell each other about it. They would make your life hell and you suffered more. Because of this, no-one really made any complaints.<sup>1423</sup>

Some victim-survivors spoke of feeling complaining was futile because they would not be believed. Max said:

Yeah, even if me and my mate had’ve made a complaint, still, that’s only two criminals against, like, four or five or, like, five or six staff members that have all got good records and that, and they’re youth workers, they’re not—the way we seen it as, there’s nothing we can do, no-one’s gonna believe us.<sup>1424</sup>

These experiences are reflected in the *Take Notice, Believe Us and Act!* report, which found that some children and young people (with experiences in detention, out of home care, education and health systems) felt unsafe raising concerns or making a complaint. Young people in detention described a culture ‘where “snitches” were frowned upon or where their adult and peer harassers retaliated when their behaviours were raised’.<sup>1425</sup>

When asked what they would do if they were unsafe or had been harmed, most children and young people interviewed for the *Take Notice, Believe Us and Act!* report

said they would turn to someone outside the institution to raise their concern or make a complaint.<sup>1426</sup> In Section 11.4, we recommend establishing an independent community visitor scheme to enable every child or young person in detention to have regular, frequent access to a trusted adult who is independent of the Department and who can advocate on their behalf.

In her submission to our Inquiry, Angela Sdrinis, a lawyer who specialises in institutional abuse claims, outlined multiple barriers to children and young people reporting child sexual abuse at Ashley Youth Detention Centre.<sup>1427</sup> These included children and young people: being unaware of complaints procedures; having an ‘ingrained distrust of authorities’; fearing being ridiculed, accused of lying or not being believed; being denied access to or avoiding external supports such as family visits; being intimidated by staff; and fearing being known as someone who reports.<sup>1428</sup> Ms Sdrinis also referred to children’s illiteracy, poor communication skills, lack of self-esteem and disempowerment due to intergenerational trauma as barriers to reporting.<sup>1429</sup>

Mark Morrissey, former Commissioner for Children and Young People, also referred to children and young people being reluctant to complain:

One thing I observed: often the culture that existed in an adult prison would reach back into the young people at Ashley. So, some of these children came from the generational situation where other family members had been in jail and they learnt the culture and the rules of a prison ... which meant not being a dog or speaking up ...<sup>1430</sup>

Mr Morrissey also highlighted the problems he observed with complaints processes at Ashley Youth Detention Centre after starting in his role in 2014. He explained that, at that time, a child or young person wishing to make a complaint had to put the complaint in writing and place it in a brightly coloured public complaints box that was in a prominent position in the Centre’s dining room.<sup>1431</sup>

Mr Morrissey stated that this was problematic because many of the children in detention were illiterate and because, in an environment where the dominant ethos was ‘don’t dob’, the public location of the complaints box was a major disincentive to making a complaint.<sup>1432</sup> As he outlined in his statement:

The chances of a young person placing a complaint or concern in the box were close to zero. Interestingly I was advised by [Ashley Youth Detention Centre] management that ‘the young people rarely if ever make complaints so I was not to expect very much’... I was not made aware of any complaints going into the complaint box between 2014 and 2017.<sup>1433</sup>

We note that, according to the *Feedback, Concern & Complaints Info Sheet* given to children and young people in detention, there are now multiple ‘post boxes’ for feedback and complaints located throughout Ashley Youth Detention Centre, rather than a single complaints box (this is discussed in Section 10.2).<sup>1434</sup>

## 10.2 Complaints processes at Ashley Youth Detention Centre

### 10.2.1 Youth Justice Act

The Youth Justice Act gives children and young people in detention the right to complain about their treatment in detention. Section 129 of the Youth Justice Act provides that a child in detention can complain to the Secretary of the Department (or the Ombudsman) about the standard of care, accommodation or treatment they are receiving in a detention centre.<sup>1435</sup>

More broadly, section 137 of the Youth Justice Act provides that a child in detention, a member of the child's family or a guardian can complain to the Secretary about any matter affecting or connected with a child in detention. Section 138 states that, on receiving a complaint, the Secretary must provide the complainant and child with written notice detailing the complaint and how the complaint will be dealt with.<sup>1436</sup> The Secretary does not have to deal with a complaint reasonably believed to be 'trivial' or 'made only to cause annoyance'.<sup>1437</sup>

### 10.2.2 Ashley Youth Detention Centre policies and procedures

We asked the Tasmanian Government to provide the policies and procedures applied to complaints made by or on behalf of children at Ashley Youth Detention Centre.<sup>1438</sup> In June 2022, we received three Ashley Youth Detention Centre complaints policies and procedures, each of which was undated:

- *Responding to Feedback, Concerns and Complaints Procedure* ('Complaints Procedure')
- *Feedback and Complaints Practice Advice* ('Complaints Practice Advice')
- a *Make a Complaint* form for children and young people.<sup>1439</sup>

The Complaints Procedure and Complaints Practice Advice were updated with effect from October 2022 and we refer to these updated versions in our discussion.<sup>1440</sup>

The Department's Practice Manual now also includes a new *Feedback, Concern & Complaints Info Sheet* ('Information Sheet') for children and young people at Ashley Youth Detention Centre (effective from October 2022) and a new *Help Form* for children and young people in detention to seek help or provide feedback (effective from September 2022) ('Help Form'), which we also discuss in Section 10.2.3.<sup>1441</sup>

In addition, there are custodial policies and procedures that guide staff who have concerns about the safety of a child or young person in detention, including concerns about the behaviour of a colleague. These are discussed separately in Section 10.2.7.

We also note that the Department’s website includes a page called ‘Complaints—Child Safety and Youth Justice Services’, which states that a person can make a complaint about a youth justice service if they are: a client of the service; a ‘friend, relative or guardian of a client’; a service provider; or ‘anyone who has a valid interest in an issue’.<sup>1442</sup> Complaints can be made to any staff member or emailed or mailed to the Department.<sup>1443</sup> The website indicates that the Department will treat complaints confidentially and try to resolve any formal complaint within four weeks of receiving it.<sup>1444</sup>

### 10.2.3 Information provided to children and young people about the complaints process

On admission to Ashley Youth Detention Centre, children and young people are given a booklet called *Information for Young People and Families*.<sup>1445</sup> This booklet advises children and young people that:

- they can complain about services at Ashley Youth Detention Centre or about the behaviour or conduct of a staff member or another young person
- they can complain to any staff member, who ‘can start the process to deal with your complaint’
- they ‘should not feel scared about making a complaint’ and can choose to ‘have a support person who can provide emotional and administrative support, make sure the complaint is dealt with fairly and promptly, and help you understand the process and the outcome’
- they have a choice as to whether their complaint is dealt with by Ashley Youth Detention Centre (in which case staff will refer the complaint to the Centre Manager) or by the Secretary of the Department (in which case staff can provide contact information, but the young person must contact the Secretary themselves)
- the Centre Manager may decide not to investigate if they believe the complaint is ‘trivial or made to cause annoyance’
- complaints referred to the Centre Manager will usually be investigated within 21 days and the young person will receive a letter telling them the outcome of their complaint
- they can ask for a review by the Secretary or the Ombudsman of a decision made about a complaint if they are not happy with it.<sup>1446</sup>

Custodial procedures also require staff to explain this information verbally to children and young people on admission.<sup>1447</sup>

The Information Sheet (also provided on admission) advises children and young people that if they want to provide feedback to Ashley Youth Detention Centre management or make a complaint they can:

- fill out a Help Form, which can be found in each unit, at Ashley School and in the ‘Health Corridor’ (discussed in Chapter 10)—once completed the form can be placed in one of several ‘post boxes’ located in the young person’s unit, at Ashley School or in the corridor near the health services
- join the ‘Resident Advisory Group’, which is a fortnightly forum designed to give children and young people detained at Ashley Youth Detention Centre ‘a say about the things that affect them’, including their views on the ‘physical amenity of the site, detention processes, standard of care, treatment and program options and how safe they feel’ (the Resident Advisory Group is discussed in detail in Section 4.6.2)
- contact the Ombudsman or the Commissioner for Children and Young People by using the phone in their unit or writing to them.<sup>1448</sup>

The Help Form is a relatively simple, two-page form that invites children and young people to write their ‘issues, problems, feedback or suggestions’ in relation to a range of areas, including safety, phone calls, food and clothing, and to tick a box indicating whether they would like the form to go the Centre Manager, the Secretary or the Ombudsman.<sup>1449</sup>

The Complaints Procedure requires Ashley Youth Detention Centre managers to ensure each unit’s meeting area displays ‘promotional feedback and complaints resources’.<sup>1450</sup>

#### 10.2.4 Process for responding to complaints from children about sexual abuse

According to the Complaints Practice Advice, where a child or young person discloses harm by a staff member, this is to be addressed by a different process—‘not the complaints process’—and staff who receive such a disclosure ‘must immediately report that to an Operations Coordinator or Manager for follow up’.<sup>1451</sup> Staff must also ‘ensure that the young person is kept safe from further harm and follow procedures regarding the notification of harm’.<sup>1452</sup>

The different process to be followed where a child or young person discloses harm is not clear to us. The Complaints Procedure refers to a separate procedure called *When a Young Person Discloses Harm*, but this document was not provided to us and we could not find it in the Department’s Practice Manual.<sup>1453</sup>

According to the Complaints Procedure:

If the young person discloses abuse (verbal, physical or sexual) by another resident or staff member, an incident report must be raised (see incident procedure).<sup>1454</sup>

This would appear to be a reference to the *AYDC Incident Reporting Procedure* (‘Incident Reporting Procedure’), although this procedure does not address harm by staff.<sup>1455</sup> The purpose of this procedure is to outline the steps that staff must take ‘following

an incident that has arisen from the behavior/s of a young person or multiple young people'.<sup>1456</sup> A central focus of the procedure is determining whether any young person involved in the incident has committed a 'detention offence' under the Youth Justice Act, rather than responding to the needs of young people affected by the incident.<sup>1457</sup>

Secretary Pervan's view was that any allegation of harmful sexual behaviours at Ashley Youth Detention Centre fell within the definition of an 'incident' for the purposes of the Incident Reporting Procedure.<sup>1458</sup> While the Incident Reporting Procedure may apply to concerns involving harmful sexual behaviours (because these could be described as constituting an incident 'arising from the behaviour' of a young person), we do not consider this procedure to be suitable to guide responses to such concerns. Viewing harmful sexual behaviours solely through the lens of 'detention offences' is inconsistent with a contemporary understanding of such behaviours (refer to Chapter 21 for a discussion of these issues). We discuss the Department's response to harmful sexual behaviours in detention in Section 8 and recommend developing a separate departmental policy to prevent and respond to such behaviours in detention (Recommendation 12.30).

As noted, the Incident Reporting Procedure does not refer to or contemplate reports or allegations of child sexual abuse or other allegations of abuse or human rights violations by staff. In her August 2022 statement to our Inquiry, Pamela Honan, Director, Strategic Youth Services, told us that she was not aware of any policy governing the Department's response to allegations of child sexual abuse as these matters are 'managed by People and Culture'.<sup>1459</sup>

In his June 2022 statement, Secretary Pervan told us that if a complaint is made about the sexual abuse of a child or young person in detention by a current staff member, 'it may be referred to the Department's People and Culture Division', which notifies Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme; undertakes an initial risk assessment (also referred to in this volume as a 'preliminary assessment') that may result in action to remove the staff member from the workplace; and prepares advice for the Secretary about whether a breach of the State Service Code of Conduct may have occurred.<sup>1460</sup>

The Secretary may then appoint an investigator to investigate the allegation in line with the procedure in Employment Direction No. 5—Breach of Code of Conduct.<sup>1461</sup> The Secretary considers the investigation report prepared by the investigator and the staff member's response to the report, and makes a determination as to any breaches of the Code of Conduct and sanctions, which may include terminating the staff member's employment.<sup>1462</sup>

Secretary Pervan said that the governance process of the People and Culture Division ensured that 'the safety of a child or young person [was] the primary consideration when responding to an allegation' and that support was made available to the complainant.<sup>1463</sup>

However, former Acting Executive Director of People and Culture, Jacqueline Allen, told us that the Department's People and Culture team:

... [did] not have documented or approved Communities Tasmania policies and procedures, relating to supporting complainants and victims; assessing and taking steps to ensure the safety of detainees; notifying other agencies of allegations; conducting investigations; decision making regarding outcomes and disciplinary processes; informing affected parties of outcomes; and record keeping.<sup>1464</sup>

Ms Allen explained that this was because the People and Culture team was not directly in contact with complainants and victim-survivors because contact was typically made through the Department of Justice (for claimants through the National Redress Scheme) or the Office of the Solicitor-General (for civil litigation complainants).<sup>1465</sup>

Ms Allen told us that, despite this, there were many informal policies and procedures that People and Culture adopted in relation to the notification process.<sup>1466</sup> For example, Employment Direction No. 5 specifically outlined how People and Culture were to conduct investigations, including how to involve a young person.<sup>1467</sup> Ms Allen also told us that, from around November 2020 onwards, once the People and Culture team was made aware of an allegation, it would inform other agencies of allegations associated with an employee.<sup>1468</sup>

Ms Allen also stated that 'People and Culture provided advice and guidance around employee related matters in the department, not resident, children or youth related matters'.<sup>1469</sup> She told us that while she had responsibility for managing parts of the complaints process, such as collecting and organising information that forms part of a preliminary assessment, neither she nor the People and Culture team had decision-making authority for Ashley Youth Detention Centre.<sup>1470</sup> Instead, Ms Allen said that the Centre's management was responsible for 'receiving and acting on complaints, allegations, and concerns regarding conduct of [Centre] officials'.<sup>1471</sup> She indicated that the People and Culture team was not directly responsible for the safety of children and young people because this responsibility sat with Ashley Youth Detention Centre management.<sup>1472</sup>

Ms Honan stated that her role was to report these matters to People and Culture.<sup>1473</sup> A discussion would occur with People and Culture about who was best to handle the complaint or allegation depending on the nature of it.<sup>1474</sup> She said that any allegations about harm of a young person by an official were referred to and managed by People and Culture.<sup>1475</sup> Ms Honan added that she did not hold an investigative role; rather, her role was to support the investigation by providing any information or documentation available to assist enquiries.<sup>1476</sup>

As illustrated here and in Chapter 11, Case study 7, the lack of clarity about the process for responding to complaints involving child sexual abuse in detention is highly problematic and places children and young people in detention at increased risk of child sexual abuse.



### 10.2.5 Process for responding to other complaints from children

In summary, the Complaints Procedure provides that the process for responding to complaints (other than those involving the disclosure of harm or abuse) is as follows:

- The Ashley Youth Detention Centre Senior Management Team discusses the complaint and appoints an ‘Investigator’ (presumably a member of staff, although this is not specified) to ‘follow up on the complaint and manage the response process’, although ‘sensitive matters (such as staff misconduct) [are] handled separately by the Director and Executive Director’, while complaints about Ashley School or the health service are referred to the manager of the relevant service.<sup>1477</sup>
- The Investigator (or their delegate) reads the complaint and speaks to the complainant ‘for further clarity’, then speaks to other ‘parties’ and ‘gathers relevant details in order to make an informed decision’.<sup>1478</sup>
- If the complaint is ‘complex’, the Investigator can ‘table it at the next [Senior Management Team] morning meeting for further consultation’.<sup>1479</sup>
- The Senior Management Team discusses the ‘final recommendation’ and determines the outcome, and the young person is informed of the outcome verbally and in writing.<sup>1480</sup>
- The outcome is recorded in the ‘complaints register’.<sup>1481</sup>

According to the Complaints Procedure, a child or young person who has made a complaint must receive an acknowledgment letter within 72 hours of lodging the complaint and a follow-up letter every 10 days until the complaint is resolved. They should also be offered support in relation to the complaint.<sup>1482</sup>

### 10.2.6 Strengths and limitations of complaints processes for children and their families

There are some positive features of the complaints processes, policies and procedures described in the preceding sections. In particular, we commend the requirement in the Complaints Procedure to provide support to a child or young person making a complaint, and to keep them informed of the investigation process.

However, we note the following structural limitations of current complaints processes and barriers to making complaints:

- Many children and young people in detention have low literacy levels. This severely limits the effectiveness of detailed written information provided to them about how to make a complaint. We are not convinced that children and young people read the information booklet given to them on admission to detention.

- While staff are also required to verbally explain complaints processes to children and young people when they are admitted to detention, admission can be an overwhelming experience and there is a risk that the child or young person will not understand or retain a verbal explanation of how to make a complaint.
- The Help Form, while simple, relies on a child or young person being able to express their concern or complaint in writing, which they may be unable or unwilling to do.
- While there are now several ‘post boxes’ throughout Ashley Youth Detention Centre for receiving written complaints, they appear to still be located in shared spaces, which may make some children and young people reluctant to use them, for fear of being perceived as a ‘snitch’.
- As noted in Section 11.4, while children and young people in detention can make phone calls to the Commissioner for Children and Young People or the Ombudsman to raise concerns or make complaints, it is not clear that such calls can always be made in private.

In an environment where there has previously been a strong culture of non-disclosure, strategies are required to overcome these structural barriers to children and young people raising concerns or making complaints.

We also note the following concerns with the current Complaints Procedure and Complaints Practice Advice:

- They do not define child sexual abuse and related conduct, including harmful sexual behaviours.
- As noted, they do not clearly explain the procedure to be followed where a child or young person discloses a safety concern (such as sexual abuse by staff or harmful sexual behaviours by another child or young person), nor do they refer to another procedure that does so.
- They do not define or provide guidance on what might constitute a ‘sensitive matter’, other than ‘staff misconduct’ (noting that, in any event, the Complaints Procedure and Complaints Practice Advice do not apply to complaints about abuse of a child or young person by a staff member).
- They do not refer to the procedure for notifying Tasmania Police, Child Safety Services or the Registrar of the Registration to Work with Vulnerable People Scheme of relevant concerns (refer to Section 10.2.7).
- They do not include mechanisms to conduct a risk assessment or undertake a root cause analysis to enable systemic improvements to be implemented following the investigation of a complaint.

- While the Complaints Procedure directs staff to record complaints in the complaints register, Secretary Pervan did not refer to this register when explaining the Centre’s complaints process.<sup>1483</sup> Secretary Pervan said that staff have recorded ‘incidents’ in the ‘Ashley Incident Monitoring System’ since January 2021.<sup>1484</sup>
- They are not publicly accessible. As noted, the Department’s website explains that complaints can be made by any person who has a ‘valid interest in an issue’ relating to a decision, a service provided or the behaviour of Child Safety and Youth Justice Services staff.<sup>1485</sup> However, aside from a short explanation of ‘what you can expect when making a complaint’, the website does not provide any policy or procedure outlining how the Department handles complaints, concerns or allegations involving children and young people in detention.<sup>1486</sup>

### 10.2.7 Complaints from staff

The Complaints Procedure and the Complaints Practice Advice are concerned with responding to complaints from children and young people rather than from staff. The Department’s Practice Manual includes the following documents to guide staff who have concerns about the safety of children and young people in detention:

- The *Contacting the SFSK Advice and Referral Line Procedure* requires staff to contact the Advice and Referral Line where they believe, suspect or know that a child or young person is at risk of, or is experiencing, abuse or neglect.<sup>1487</sup> This procedure advises staff who become aware of historical or current concerns about the conduct of another employee ‘as it relates to the safety of children and young people’ to immediately report those concerns to their supervisor and contact the Advice and Referral Line.<sup>1488</sup>
- The *Reporting Concerns* fact sheet advises staff ‘to report any conduct or behaviour which is of concern to you, and that could compromise the safety and wellbeing of a child’.<sup>1489</sup> Concerns about the conduct of another staff member must be reported to the Department’s People and Culture team, to the Advice and Referral Line and, ‘[i]f the concerning behaviour is criminal in nature’, to Tasmania Police.<sup>1490</sup> Staff should also discuss their concerns with their supervisor or manager as soon as practicable.<sup>1491</sup> The fact sheet acknowledges that ‘these matters can cause significant distress for employees and can be confronting and disturbing’ and indicates that ‘[e]xtensive support is available to all employees’, including support from the employee’s manager and from ‘Health and Wellbeing Officers’.<sup>1492</sup>
- More broadly, the *Transparency and Accountability* policy requires staff to comply with the State Service Code of Conduct, to ‘[c]ommunicate when things go wrong so that matters can be addressed at the earliest possible moment’ and to ‘[f]oster a no blame culture to promote practice improvement’.<sup>1493</sup>

None of these documents defines or explains child sexual abuse, harmful sexual behaviours, grooming or professional boundary breaches.

Even where there are clear policies and procedures requiring staff to report concerning behaviour on the part of colleagues, staff may be unlikely to report where the culture does not enable or encourage this—for example, where staff feel that they may be labelled ‘difficult’ or ‘hysterical’, their concerns may be minimised by management, or they may experience reprisals. In Section 4, we make a series of recommendations aimed at creating a child safe culture in youth detention. We also consider that there are opportunities to encourage and empower staff in youth detention to report concerning conduct on the part of their colleagues. These are discussed in Section 10.3.1.

### 10.2.8 Planned reforms

The Keeping Kids Safe Plan, released in October 2022, indicated that the Department was ‘[d]eveloping and implementing a robust internal complaint system (for both children and young people and staff)’ at Ashley Youth Detention Centre.<sup>1494</sup>

In February 2023, Secretary Bullard advised us that the Department had begun a ‘complaints management review project’ with a view to aligning its approach with other government agencies such as the Department of Health.<sup>1495</sup> The Department for Education, Children and Young People’s *Project Initiation Plan – Complaints Management Review* states that a review of complaints functions has occurred in the Children and Families and the Education portfolios, but has yet to be undertaken for ‘functions within Youth Justice’.<sup>1496</sup>

We also note that the Department’s *Safeguarding Framework* describes broadly how the Department will implement Standard 6 of the Child Safe Standards—‘Processes to respond to complaints and concerns are child-focused’—including ways for people and children to report concerns, for providing trauma-informed support following disclosure, for record keeping and for transparent communication.<sup>1497</sup> However, it is not clear how this will be applied to children and young people in detention.

## 10.3 Improving complaints processes

The *Take Notice, Believe Us and Act!* report found that, for children and young people to feel able to raise a concern or disclose abuse or mistreatment, they needed:

- to know what complaints processes were in place and how to access them<sup>1498</sup>
- to have at least one trusted adult they could turn to<sup>1499</sup>
- to have confidence that they would be believed<sup>1500</sup>
- to know that adults and organisations would take their concerns seriously and respond quickly and effectively, so things would change for the better<sup>1501</sup>
- to know they would be protected from any consequences or repercussions.<sup>1502</sup>

As noted in Section 11.4, we recommend establishing an independent community visitor scheme for children and young people in detention. This would give each child and young person a trusted adult to speak to regularly and frequently, who would be independent of the Department and would have the power to advocate on the child or young person's behalf. The other features identified by children and young people in the *Take Notice, Believe Us and Act!* report are addressed in the following discussion.

### 10.3.1 Encouraging complaints and critical feedback

The Department needs to take active steps to create a culture in which complaints and critical feedback are encouraged. This is essential to overcome children's and young people's mistrust of and lack of confidence in complaints processes and the dominant culture of not 'dobbing'.

It is important to ensure children and young people in detention understand the complaints process and feel safe making a complaint. This requires them to know what to expect when making a complaint, what steps the Department or the facility will take in response to a complaint and how complainants will be protected against repercussions.

As outlined in Section 10.2.6, there are several structural barriers to children and young people in detention making complaints, including low literacy levels and a heavy reliance on information provided to children and young people during admission. The Department should ensure its complaints processes address these barriers.

In our view, children and young people in detention should be regularly, actively reminded about feedback and complaints processes throughout their time in detention, using a variety of developmentally appropriate mechanisms. These could include visual materials displayed in every unit and regular information sessions on how to make a complaint. Implementation of the independent community visitor scheme recommended in Section 11.4 will also provide a regular reminder to children of their right to make a complaint.

Children and young people also need to be empowered and feel confident to make complaints. We acknowledge that such confidence may only develop once children and young people begin to use the complaints process and see quick, decisive, effective action taken in response to their complaints, without negative repercussions for them. Building this confidence may take time.

Nevertheless, as Mr Morrissey stated, it is important as part of a therapeutic environment to give children and young people the 'skills and permission to have a voice'.<sup>1503</sup> In Section 4.6, we make recommendations aimed at promoting the voices of children and young people in detention and empowering them to have input into detention centre operations and processes. In particular, we recommend that the Department reviews and strengthens the Ashley Youth Detention Centre Resident Advisory Group.

The families and guardians of children and young people in detention also need to be made aware of, and have confidence in, departmental complaints processes. In the Australian Capital Territory, the complaints management policy for responding to a complaint about youth detention is publicly available.<sup>1504</sup> We recommend that the Department develops and publishes a guide to making a complaint about youth detention, so anyone with a concern about a child or young person in detention has an easily accessible complaint pathway.

Staff in detention facilities also need to be encouraged to report concerns about their colleagues, make complaints and provide feedback without fear of reprisal. In Chapter 15, we discuss programs used in the health sector to improve organisational culture and encourage staff to speak up if they observe concerning actions or behaviour—in particular, the ‘Speaking up for Safety’ program, which is being implemented at Royal Hobart Hospital.<sup>1505</sup>

In Chapter 15, we also discuss the Ethos Program, which is a peer-based early intervention program designed to recognise staff who demonstrate positive behaviours, remove barriers from speaking up about concerns that affect patient or staff safety, and allow for a quick, fair and transparent response to all staff, including those making a complaint and those with concerning behaviours.<sup>1506</sup> Under the Ethos Program:

- staff are trained on how to ‘speak up’ effectively and can use an online messaging system to submit feedback for recognition (to acknowledge positive behaviour) or reflection (to offer feedback for improvement)<sup>1507</sup>
- feedback is delivered by a trained ‘Ethos Messenger’, who is generally a peer of the staff member, via an informal conversation<sup>1508</sup>
- trained staff triage reports received through the Ethos messaging system across four levels, depending on the seriousness of the incident.<sup>1509</sup>

In Chapter 15, we recommend that the Department of Health considers integrating features of the Ethos Program into its cultural improvement program (Recommendation 15.4). A similar reporting system that applies to all staff could also be a valuable initiative for creating a culture that enables the giving and receiving of feedback in youth detention.

### **10.3.2 Responding to complaints—the role of the Child-Related Incident Management Directorate and the Harmful Sexual Behaviours Support Unit**

In Chapter 6, we recommend establishing a Child-Related Incident Management Directorate to receive, assess, investigate, coordinate and oversee the Department’s responses to allegations of child sexual abuse and related conduct (including grooming and professional boundary breaches), and other harms to children and young people by staff (Recommendation 6.6).

The Child-Related Incident Management Directorate would have three functions:

- an incident report management function, which would be responsible for assisting child-facing services in the Department (such as Ashley Youth Detention Centre) with managing incidents or allegations against staff, including being the point of contact for these services—this function should be responsible for ensuring the relevant government institution takes appropriate actions in relation to matters referred to the Directorate
- an investigations function, comprising appropriately trained and skilled investigators who would undertake preliminary assessments, investigate incidents of alleged misconduct (including allegations of child sexual abuse) and prepare reports for misconduct adjudicators to consider
- a misconduct disciplinary advice function that involves misconduct adjudicators examining reports prepared by investigators on incidents of alleged misconduct, assessing whether misconduct has been established and, where there may have been a breach of departmental policies, preparing a report recommending a course of action for the Secretary.

The recommended approach is based on the South Australian Department for Education’s system for responding to and investigating complaints of child sexual abuse.<sup>1510</sup> In our view, the South Australian model embodies many of the features that the National Royal Commission recognised as being instrumental to an institution’s ability to respond to concerns or complaints of child sexual abuse in a way that is sensitive and child-focused. These include:

- investigations being conducted by impartial, objective, trained investigators<sup>1511</sup>
- children being interviewed by people with relevant specialist skills (for example, knowledge of child development, trauma-related behaviours, indicators of abuse and investigative techniques)<sup>1512</sup>
- responding to complainants in a sensitive, supportive and protective way and ensuring affected parties (including the subject of the complaint) have access to support, therapeutic treatment services and advocacy.<sup>1513</sup>

The Child-Related Incident Management Directorate would be responsible for leading the response to allegations of child sexual abuse by staff across all portfolios of the Department, namely education, out of home care and youth justice.

In relation to youth detention, we recommend the following:

- All concerns and complaints involving allegations of child sexual abuse and related conduct (including grooming and boundary breaches) or other harms to children (including the inappropriate use of force, isolation or searches) by staff should be referred immediately to the Child-Related Incident Management Directorate.



- The incident report management function of the Child-Related Incident Management Directorate should be responsible for ensuring detention centre management communicates appropriately with children and young people affected by an allegation against a staff member, as well as their parents or carers.
- The incident report management function and the investigations function of the Child-Related Incident Management Directorate should be performed by staff with knowledge and understanding of the youth justice system, and an understanding of the characteristics of abuse and mistreatment of children and young people in detention. This is particularly important in view of the widespread and systematic abuse experienced by some children and young people at Ashley Youth Detention Centre, as illustrated in Chapter 11, Case study 1.

In the case of concerns or complaints about harmful sexual behaviours, in Chapter 9 we recommend that the Department establishes a Harmful Sexual Behaviours Support Unit (Recommendation 9.28) in the new Office of the Chief Practitioner (Recommendation 9.17). We recommend that this unit supports all child-facing services in the Department, including youth justice services, to manage harmful sexual behaviours through the provision of advice, guidance and support. The Harmful Sexual Behaviours Support Unit should work closely with the new Quality and Risk Committee (Recommendation 9.5) to ensure systemic risks, practice issues and opportunities for improvement are identified.

In Section 8.5 of this chapter, we recommend (in Recommendation 12.30) that:

- the Harmful Sexual Behaviours Support Unit develops detailed policies, protocols and guidelines to support best practice responses to harmful sexual behaviours displayed in youth detention or other residential youth justice facilities
- all complaints about harmful sexual behaviours in youth detention or other residential youth justice facilities be reported to the Harmful Sexual Behaviours Support Unit and to the new Commission for Children and Young People.

The question then arises as to whether other, non-serious concerns and complaints about youth detention should also be automatically escalated within the Department. We note that in the Australian Capital Territory, the complaints management policy for children and young people in detention aims to ‘resolve complaints quickly and effectively and at the lowest level of formality possible’, stating that:

In many cases, concerns and complaints can be resolved quickly and effectively through informal communication with young people, their family members or significant others. In some cases a young person may simply want to have the reasons for a decision clearly explained to them, or may want an opportunity to have their views and concerns listened to and taken seriously.<sup>1514</sup>

Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre, in the Australian Capital Territory, told us that '[a]s much as possible young people are encouraged to speak with their supervising Youth Worker, Team Leader and/or Unit Manager to address their concerns'.<sup>1515</sup>

The Australian Capital Territory's complaints management policy places clear obligations on staff to 'take the time to stop, listen and respond' to any concerns raised by children and young people in a supportive and consistent manner because this may 'reduce the need for complainants to escalate their concerns into formal complaints'.<sup>1516</sup> However, the policy also states that '[u]nder no circumstances should staff try to talk a child or young person out of making a complaint'.<sup>1517</sup> If the child or young person wants to make a complaint, staff should help them to do so.<sup>1518</sup> Unit Managers will typically investigate complaints, but serious matters must be escalated to the Manager and the Director, Child and Youth Protection Services Operations.<sup>1519</sup>

We are mindful of the voices of victim-survivors who spoke of feeling there was no point in making a complaint to Ashley Youth Detention Centre because they felt they would not be believed or would suffer reprisals. We note that most of the matters about which victim-survivors remained silent would constitute serious complaints that would be escalated to the new Child-Related Incident Management Directorate under our recommended complaints-handling system.

We are also mindful that it may be impractical and not in a child's or young person's best interests for all minor concerns or complaints about youth detention to be escalated within the Department for investigation; for example, it may delay resolving the complaint. On this basis, we recommend that the primary responsibility for responding to non-serious concerns and complaints remains with management and staff of the detention facility.

### 10.3.3 Other recommended improvements to complaints processes

The Complaints Procedure and Complaints Practice Advice should be updated to reflect the changes recommended in Sections 10.3.1 and 10.3.2 and to:

- demonstrate the ways in which specific barriers to making complaints in detention settings have been addressed
- clearly define child sexual abuse and related conduct, including sexual misconduct, (consistent with the Child and Youth Safe Organisations Act—discussed in Chapter 18), grooming and boundary breaches
- set timeframes for responding to complaints
- specify any voluntary or mandatory reporting obligations
- specify requirements for communicating with and providing support to complainants and other affected people

- include procedures for formalising complaints received verbally, via email or other means where it is clear that the intent of the person is to make a complaint
- clarify requirements for recording complaints and investigation outcomes
- ensure complaints processes apply to any new detention facility designed to replace Ashley Youth Detention Centre, as well as other residential youth justice facilities, including the proposed assisted bail facilities and supported residential facilities (discussed in Sections 5.4.5 and 6.8.2 respectively).

The role of detention centre staff in complaints processes should be to respond supportively and proactively to concerns raised by children and young people, explain complaints processes to them and support them to make a complaint. They should understand which concerns and complaints must be referred immediately to the Child-Related Incident Management Directorate, and their mandatory and voluntary reporting obligations.

Staff receiving a complaint need to consider the intent of the person raising the issue—if it is clear they are making a complaint or reporting a serious incident, it needs to be treated as such, regardless of whether it is raised verbally, via email or using another mechanism, and regardless of whether it is made using the right form.

In Section 4.7.3, we recommend that professional development for staff includes training on all departmental policies and procedures (Recommendation 12.9). This should include training on complaints processes. In Section 4.8, we recommend that the Department develops a professional conduct policy that sets out the standards of behaviour expected of those who work in youth detention and other youth justice facilities, including contractors and volunteers (Recommendation 12.10).

## **Recommendation 12.35**

The Department for Education, Children and Young People should:

- a. update its complaints procedure and practice advice for youth detention to
  - i. address structural barriers to making complaints in detention and include developmentally appropriate communication methods at all stages
  - ii. require concerns, regardless of the form in which they are raised, to be recognised, recorded and actioned as a complaint where the person raising the concern wants to make a complaint
  - iii. define child sexual abuse (including sexual misconduct, grooming and harmful sexual behaviours) and boundary breaches

- iv. require all complaints and concerns involving allegations of child sexual abuse and related conduct or other harms to children (including the inappropriate use of force, isolation or searches) by staff, breaches of the State Service Code of Conduct or the professional conduct policy for youth detention (Recommendation 12.10) and reportable conduct as defined by the *Child and Youth Safe Organisations Act 2023* to be referred immediately to the new Child-Related Incident Management Directorate for response (Recommendation 6.6)
  - v. require all incidents involving harmful sexual behaviours to be reported to the Harmful Sexual Behaviours Support Unit (Recommendation 9.28)
  - vi. clearly specify mandatory and voluntary reporting obligations for staff in relation to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*
  - vii. set timeframes for responding to complaints
  - viii. specify requirements for communicating with and providing support to complainants and other affected parties, including parents or carers of affected children and young people
  - ix. clarify the requirements for recording complaints and outcomes of complaint investigations to enable the monitoring of trends for quality, safety and governance purposes
  - x. include procedures for making and responding to complaints in relation to other residential youth justice facilities, including the proposed assisted bail and supported residential facilities
- b. ensure staff in detention and other residential youth justice facilities understand and comply with their role in responding to complaints, including complaints about child sexual abuse, and have a clear process for raising safety concerns about other staff
  - c. use a range of child-friendly tools to ensure children and young people in detention and other residential youth justice facilities are aware of complaints processes and understand the steps facility staff and the Department will take in response to a complaint, including a complaint about child sexual abuse

- d. ensure a child-friendly guide to making a complaint and explaining complaints procedures, including the circumstances under which complaints made to oversight bodies may be referred to the Department, is readily accessible on the Department's website, as well as a guide for adults wishing to make a complaint on behalf of a child in detention or another residential youth justice facility
- e. ensure there are staff in the Child-Related Incident Management Directorate with expertise in youth justice, including an understanding of the risks of child sexual abuse in detention and the characteristics of mistreatment and abuse in detention environments.

## 11 Independent oversight of youth detention

Independent external oversight is a vital component of safeguarding children and young people held in a closed facility such as Ashley Youth Detention Centre, where contact with people outside the facility is heavily controlled, regulated and limited.

To help identify and minimise the risks of child sexual abuse, children and young people in detention must have access to regular visits from the staff of an independent oversight body who have the interpersonal skills, cultural competency and professional background to build rapport and trust with them.<sup>1520</sup>

Children must also be empowered to engage with and participate in complaints and monitoring mechanisms while in detention.<sup>1521</sup> They should feel confident to raise concerns with an oversight body and to make a formal complaint where necessary. This requires oversight bodies to be reliable, trustworthy and adequately resourced, and to communicate effectively with each other so children and young people in detention get useful responses to complaints, without negative repercussions.<sup>1522</sup>

Youth detention oversight bodies must also be proactive, particularly where children and young people may be reluctant to raise concerns or make complaints.<sup>1523</sup>

According to Stephen Kinmond OAM, former New South Wales Deputy Ombudsman (Human Services) and current New South Wales Children's Guardian with responsibility for overseeing reportable conduct:

... if a particular agency or sector has demonstrated low reporting rates, it is important for the oversight body to take timely action. Indeed, for the [New South Wales reportable conduct scheme], the Ombudsman's ability to undertake auditing activities was a critical function in assisting an agency to improve its systems and practices for providing safe environments for children in its care.<sup>1524</sup>

As the National Royal Commission noted, oversight bodies such as inspectors of custodial services, visitor schemes, children’s commissioners and guardians, and ombudsman offices can mitigate the heightened risks of child sexual abuse associated with a secure, locked youth detention facility and ensure greater transparency and accountability.<sup>1525</sup>

The National Royal Commission recommended that:

State and territory governments should ensure they have an independent oversight body with the appropriate visitation, complaint handling and reporting powers to provide oversight of youth detention. This could include an appropriately funded and independent Inspector of Custodial Services or similar body. New and existing bodies should have expertise in child-trauma, and the prevention and identification of child sexual abuse.<sup>1526</sup>

As mentioned in Section 10, the National Royal Commission also recommended that state and territory governments review existing external complaints-handling systems concerning youth detention centres to ensure they are capable of effectively dealing with complaints of child sexual abuse, so:

- children can easily access child-appropriate information about external oversight
- children have confidential and unrestricted access to external oversight bodies
- staff involved in managing complaints internally and externally include Aboriginal people and professionals qualified to give trauma-informed care
- complaints-handling systems are accessible for children with literacy difficulties or who speak English as a second language
- children are regularly consulted about the effectiveness of complaints-handling systems and systems are continually improved.<sup>1527</sup>

The *Take Notice, Believe Us and Act!* report confirmed the importance of all children and young people in detention having access to external advocates who could proactively seek their views and respond when they had safety concerns.<sup>1528</sup> However, as outlined in Section 10.1 and described in Section 11.2, some victim-survivors who were or had been in detention told us that they did not know who to contact to make a complaint, they did not feel safe making a complaint and, when they did complain, there was no action or response.

As noted, it is essential for children and young people in detention to feel safe to disclose sexual abuse or other mistreatment to an independent oversight body. However, it is not enough for an oversight body to rely solely on disclosures or complaints from children and young people in detention for the proper performance of its functions. An effective oversight body in the youth detention context is one that understands that youth detention exposes children and young people to a higher risk of sexual abuse and is cautious if there are low rates of complaints.<sup>1529</sup>

We note that the youth justice reforms outlined in the Keeping Kids Safe Plan, Draft Youth Justice Blueprint and Draft First Action Plan do not indicate any intention to reform current youth justice oversight mechanisms.<sup>1530</sup>

In this section, we recommend:

- establishing an independent community visitor scheme for children and young people in detention, to give them an independent, trusted adult to whom they can speak regularly, with whom they can safely and confidently raise concerns, and who will advocate on their behalf
- improving the Ombudsman’s processes for handling complaints containing allegations of sexual abuse involving children and young people in detention
- strengthening and improving systemic monitoring of Tasmania’s youth detention facilities.

## 11.1 Tasmania’s system of oversight for youth detention

Several bodies in Tasmania are responsible for independently monitoring the safety and wellbeing of children and young people in youth detention. Collectively, the Commissioner for Children and Young People, Ombudsman and Custodial Inspector provide independent, external oversight for children and young people held in Ashley Youth Detention Centre.<sup>1531</sup> Their roles are described in the following sections.

Also, in February 2022, the Tasmanian Government announced that it had appointed Richard Connock as a Tasmanian National Preventive Mechanism following the enactment of the *OPCAT Implementation Act 2021* in November 2021.<sup>1532</sup> Mr Connock is also the Ombudsman, Custodial Inspector, Tasmanian Health Complaints Commissioner, Energy Ombudsman and de facto Information and Privacy Commissioner.<sup>1533</sup> The National Preventive Mechanism, established in line with OPCAT, is an independent body tasked with preventing torture. Its key function is:

... to regularly examine the treatment of persons deprived of their liberty in places of detention with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment.<sup>1534</sup>

The role does not investigate complaints.<sup>1535</sup> The Tasmanian National Preventive Mechanism is discussed in Section 11.7.

In this section, we discuss oversight functions exercised over individual children and young people in youth detention and the youth detention system itself. For individuals, we distinguish between advocacy on behalf of an individual child—including visiting a child in detention, helping them to raise any concerns about their experience in detention and seeking resolution of those concerns—and the formal investigation of a complaint about detention made by a child or young person.



As discussed in Chapter 18, the current oversight arrangements for institutions responsible for children and young people are complex and fragmented. This is true of youth detention. Table 12.1 summarises the functions of the Commissioner for Children and Young People, the Ombudsman and the Custodial Inspector in respect of youth detention. These functions are then discussed in the following sections.

**Table 12.1: Overview of current youth detention oversight system**

Function	Commissioner for Children and Young People	Ombudsman	Custodial Inspector
Visiting an individual child in detention and listening to their concerns	●		
Advocating on behalf of an individual child in detention (including assisting the child to make a formal complaint)	●		
Investigating a complaint from a child about detention		●	
Inspecting detention facilities			●
Monitoring the wellbeing of children in detention	● (as part of general function of monitoring the wellbeing of all Tasmanian children)		● (as part of inspection function)
Making recommendations to government about children in detention or the detention system	●	●	●

### 11.1.1 Commissioner for Children and Young People

The Commissioner for Children and Young People is an independent statutory officer appointed by the Governor on the advice of the Minister for Education, Children and Youth under the *Commissioner for Children and Young People Act 2016* ('Commissioner for Children and Young People Act').<sup>1536</sup> As mentioned earlier, the Commissioner for Children and Young People is Leanne McLean, who was appointed in November 2018.<sup>1537</sup>

The general functions of the Commissioner for Children and Young People are described in Chapter 18. These functions are broad and include advocating for all children and young people, as well as promoting, monitoring and reviewing the wellbeing of children and young people in Tasmania.<sup>1538</sup>

The statutory functions of the Commissioner for Children and Young People do not specifically refer to monitoring the wellbeing of children and young people in youth detention or monitoring the operation of the youth justice system more broadly. However, the Commissioner for Children and Young People Act specifies that it must be administered in line with several principles, including that the interests and needs of 'vulnerable' children and young people—defined to include detainees and former detainees—should be given special regard and serious consideration.<sup>1539</sup>

The Act also requires the Commissioner for Children and Young People to act ‘as advocate for a detainee under the *Youth Justice Act 1997*’.<sup>1540</sup> This entails:

- a. listening to, and giving voice to, the concerns and grievances of the detainee and facilitating the resolution of those concerns and grievances
- b. seeking information about, and facilitating access by the detainee to, support services appropriate to the needs of the detainee
- c. assessing whether the detainee has been provided with adequate information about his or her rights
- d. assessing, in the Commissioner’s opinion, the physical and emotional wellbeing of the detainee.<sup>1541</sup>

The Commissioner for Children and Young People is a ‘prescribed officer’ for the purposes of section 135A of the *Youth Justice Act*.<sup>1542</sup> This entitles the Commissioner to access, at any reasonable time, any detention centre for the purposes of performing functions under the Commissioner for Children and Young People Act, and to visit any detainee at a centre for the purposes of performing functions under the *Youth Justice Act* in relation to the detainee.<sup>1543</sup> The detention centre staff and manager must allow the Commissioner for Children and Young People to conduct an interview with a detainee ‘out of the hearing of any other person’ and must not, without the approval of the detainee, open, copy, remove or read any correspondence between the detainee and the Commissioner.<sup>1544</sup>

The Commissioner for Children and Young People does not have the power to investigate or review decisions made about individuals. An exception applies where the Minister for Education, Children and Youth requests that the Commissioner investigates or reviews a decision or recommendation made, or an act or omission, under any Act.<sup>1545</sup> In these circumstances, the Commissioner can undertake an investigation or review that is outside of their general jurisdiction.<sup>1546</sup> Commissioner McLean told us that she had not been asked to undertake such an investigation during her term as Commissioner for Children and Young People.<sup>1547</sup>

The Commissioner for Children and Young People can: provide a child, or the child’s family, with information about relevant government and non-government programs or services; refer a child to such programs or services; or investigate or otherwise deal with any matter affecting the wellbeing of children generally when it is raised through a matter relating to a specific child.<sup>1548</sup> This general power in relation to all children applies equally to children in detention. The Commissioner for Children and Young People can also refer any matter to the Ombudsman or Custodial Inspector if the Commissioner considers it appropriate.<sup>1549</sup>

Commissioner McLean indicated that she visits Ashley Youth Detention Centre every three weeks and that during 2020–21 she visited 15 times.<sup>1550</sup> She said she meets with

children and young people in a quiet space if they request this, and with or without a youth worker present.<sup>1551</sup> She also advised that she participates in programs, visits young people in their units and can move through the Centre unaccompanied.<sup>1552</sup>

Commissioner McLean explained that she can assist children and young people to make a complaint to relevant authorities, which most commonly involves raising a complaint directly with Ashley Youth Detention Centre management, the Secretary of the Department, the Ombudsman or Tasmania Police.<sup>1553</sup>

In February 2022, an Advocate for Young People in Detention was appointed to assist Commissioner McLean to perform her youth detainee advocacy functions and meet the demand for help with making a complaint:<sup>1554</sup>

... we now have a full-time advocate for young people in detention who lives in the North West of the state, who's present on site very regularly and has a mobile phone whose number is available to all detainees from admission. So, since the instigation of that additional resource we have seen a dramatic increase in the call on our advocacy and also an increase in the call upon us to facilitate a complaint.<sup>1555</sup>

However, despite her regular visits to Ashley Youth Detention Centre, Commissioner McLean told us that, as at 12 April 2022, no child or young person detained there had raised with her allegations of child sexual abuse perpetrated by staff.<sup>1556</sup>

In her statement to our Commission of Inquiry, Commissioner McLean identified four instances where she had been made aware (from a source other than a child) of child sexual abuse allegations involving children and young people at Ashley Youth Detention Centre.<sup>1557</sup> These instances largely related to potential harmful sexual behaviours displayed by young people or historical allegations of abuse.<sup>1558</sup> Commissioner McLean told us that she generally responded by referring the matters to other relevant authorities, discussing issues with the (former) Department of Communities, monitoring progress and outcomes of any reviews and, in one case, providing advocacy for a young person.<sup>1559</sup>

We acknowledge that the Commissioner for Children and Young People currently has no statutory power to investigate such incidents on her own motion, or to investigate departmental responses to such allegations. Nevertheless, the handling of these incidents highlights the limitations of, and weaknesses in, Tasmania's current system of oversight of youth detention, where the Commissioner for Children and Young People is reliant on the assurances of the Department and lacks the power to inquire into the accuracy of those assurances.

We note that if these or similar incidents occurred in future, those involving allegations against staff would be subject to the Reportable Conduct Scheme under the Child and Youth Safe Organisations Act (discussed in Chapter 18). Under this scheme, an allegation that a 'worker' at Ashley Youth Detention Centre engaged in 'reportable conduct' (such as sexual offences, sexual misconduct or grooming) against a child or young person

in detention would need to be notified to the Independent Regulator and investigated by the head of the detention facility (as the ‘relevant entity’).<sup>1560</sup> This is the Secretary of the Department, or their delegate.

Under the Child and Youth Safe Organisations Act, the Independent Regulator of the Reportable Conduct Scheme would be responsible for monitoring the investigation. It would receive: a copy of investigation findings, with reasons for the findings; details of any disciplinary or other action taken by management against the worker; and, where no action was proposed, the reasons for this decision.<sup>1561</sup> The Independent Regulator would also have the power to investigate an allegation of reportable conduct on the Independent Regulator’s own motion, if it considered that this was in the public interest.<sup>1562</sup>

We strongly support the introduction of a reportable conduct scheme in Tasmania. In Chapter 18, we recommend establishing a new Commission for Children and Young People (Recommendation 18.6), which should assume the functions of the Independent Regulator of the Reportable Conduct Scheme. We discuss the new Commission for Children and Young People in Section 11.3.

We note that concerns about children and young people in detention who have engaged in harmful sexual behaviours against other children and young people in detention would not be subject to the Reportable Conduct Scheme because that scheme does not extend beyond reportable conduct by a ‘worker’ (defined as a person aged 18 years or older). In Section 8.5, we recommend that the Department be required to notify the new Commission for Children and Young People of incidents involving harmful sexual behaviours in youth detention, so the Commission has a complete picture of what is occurring in youth detention (Recommendation 12.30).

As discussed in Chapter 18, despite the statutory requirement that the Commissioner for Children and Young People acts ‘independently, impartially and in the public interest’, we heard evidence that cast doubt on the operational independence of the role.<sup>1563</sup> In particular, former Commissioner for Children and Young People Mark Morrissey recounted several experiences where he felt the independence of his office had been undermined by the Government (these are described in Chapter 18). Mr Morrissey referred to:

... an apparent attempt to undermine the *raison d’être* of the [Commissioner for Children and Young People]—namely as an independent voice legitimately advocating for children and young people, particularly vulnerable and at-risk children.<sup>1564</sup>

Mr Morrissey said that, following these experiences, he found it increasingly difficult to have his message accepted about child protection reform work and decided to retire.<sup>1565</sup> He also indicated that his two predecessors had not continued in their roles for the full intended duration of their appointments, but did not specify or speculate as to why.<sup>1566</sup>

As discussed in Chapter 18, lack of control over resourcing can also impede the independence of an oversight body. Commissioner McLean noted that, in contrast to the Ombudsman, who has control of his own budget and has a separate appropriation, the budget for the Commissioner for Children and Young People is an output item from the (former) Department of Communities budget.<sup>1567</sup> Commissioner McLean also told us that resourcing for her office ‘has remained a constant challenge’ and resourcing constraints have limited her ability to fulfil her functions.<sup>1568</sup> The funding allocated to the Commissioner for Children and Young People was \$1,386,000 in 2021–22.<sup>1569</sup> In Chapter 18, we discuss independent resourcing of the new Commission for Children and Young People.

### 11.1.2 Ombudsman

The Ombudsman is an independent statutory officer appointed under the *Ombudsman Act 1978*.<sup>1570</sup> The Ombudsman has a role both in relation to individuals and the youth detention system (refer to Table 12.1). As noted, the position is currently held by Richard Connock.<sup>1571</sup>

The primary role of the Ombudsman is to investigate the administrative actions of public authorities to ensure they are lawful, reasonable and fair.<sup>1572</sup> The Ombudsman may receive complaints from people who are aggrieved by the administrative actions of public authorities if they have not been successful in resolving their complaint directly with the authority.<sup>1573</sup> This includes complaints from children and young people in detention about their treatment in Ashley Youth Detention Centre.<sup>1574</sup>

Under the Youth Justice Act, a child or young person detained at a youth detention centre is entitled to complain to the Ombudsman about the standard of care, accommodation or treatment they are receiving in the detention centre.<sup>1575</sup> Where a child or young person in detention wants to make a complaint to the Ombudsman, staff of the detention centre must take all steps necessary to facilitate the complaint and must send the Ombudsman an unopened, sealed envelope containing the complaint.<sup>1576</sup>

The Ombudsman’s 2021–22 annual report indicates that most complaints across all public authorities are resolved by way of ‘preliminary inquiries’—this involves a ‘co-operative approach’ where authorities provide information and work with the Ombudsman to address complaints and improve processes.<sup>1577</sup> However, where appropriate, the Ombudsman may conduct an investigation on the basis of a complaint or on the Ombudsman’s own motion.<sup>1578</sup> Following an investigation, a report is prepared for the public authority and this may contain recommendations to remedy actions.<sup>1579</sup> The report may also be provided to the relevant Minister and to Parliament.<sup>1580</sup> The Ombudsman does not have the power to compel a public authority to adopt any recommendations, although these ‘are ordinarily accepted and acted upon’.<sup>1581</sup>

The Ombudsman advised us that his office receives ‘very few, if any’ complaints about child sexual abuse.<sup>1582</sup> The Ombudsman’s most recent annual report indicates that the Ombudsman received two complaints about Ashley Youth Detention Centre in 2021–22, up from one complaint in 2020–21.<sup>1583</sup> The annual report provides no more information on the nature of these complaints.

Case studies 1 and 7 in Chapter 11 examine the former Ombudsman’s response to a complaint made by Erin (a pseudonym) in 2012 about the sexually inappropriate behaviour of a male youth worker at Ashley Youth Detention Centre. The then Ombudsman referred the allegations to Ashley Youth Detention Centre management and finalised the complaint.<sup>1584</sup>

We are aware of other complaints about the behaviour of staff at Ashley Youth Detention Centre that the then Ombudsman classified as ‘minor’ and referred in error to Centre management for internal review between 2009 and 2013.<sup>1585</sup> In our view, the allegations in these complaints were not minor in nature. In Chapter 11, Case study 7, we observe that this historical arrangement between the Office of the Ombudsman and the Department, at least on occasion, resulted in serious matters being erroneously referred back to the Centre in and around 2012. In that case study, we also express our concern about the integrity of the processes which were in place in the Office of the Ombudsman at the time to ensure inappropriate referrals were not made.

The current Ombudsman advised us that this arrangement is no longer in place.<sup>1586</sup> Mr Connock said that the Ombudsman’s Office now conducts preliminary enquiries for ‘any complaint’ it receives.<sup>1587</sup> We have not been advised about how this process has been formalised.

We also understand that Ashley Youth Detention Centre management has, in the past, advised staff that they should not have direct contact with the Offices of the Ombudsman or Custodial Inspector, and that all enquiries from those offices must be escalated to senior management.<sup>1588</sup>

### 11.1.3 The Custodial Inspector

The Office of the Custodial Inspector was established by the *Custodial Inspector Act 2016* (‘Custodial Inspector Act’) and commenced operation in November 2016.<sup>1589</sup> The purpose of the office is to ‘provide independent, proactive, preventive and systemic oversight of custodial centres’, including Ashley Youth Detention Centre.<sup>1590</sup> The Custodial Inspector must act independently, impartially and in the public interest.<sup>1591</sup>

As noted, the current Custodial Inspector is Mr Connock, who also holds several other appointments.<sup>1592</sup>

The Custodial Inspector's functions include:

- preparing and publishing guidelines and standards for conducting inspections<sup>1593</sup>
- carrying out a mandatory inspection of each custodial centre against all inspection standards at least once every three years, and any occasional inspections of the Custodial Inspector's own accord or as requested by the Minister for Corrections and Rehabilitation<sup>1594</sup>
- reporting to the Minister or Parliament on the inspections, and any particular issue or general matter relating to the functions of the Custodial Inspector, if it is in the public interest to do so, or if requested by either House of Parliament or a Committee of either House of Parliament<sup>1595</sup>
- providing an annual report to Parliament<sup>1596</sup>
- providing advice or making recommendations that the Custodial Inspector thinks appropriate, including advice or recommendations relating to the safety, custody, care, wellbeing and rehabilitation of prisoners and detainees.<sup>1597</sup>

The Custodial Inspector has published *Inspection Standards for Youth Custodial Centres in Tasmania*, comprising standards under nine themes: governance and procedural fairness; informed advice; service delivery; family and community; partnerships; infrastructure; workforce; security; and health and wellbeing.<sup>1598</sup>

The Custodial Inspector does not respond to individual complaints.<sup>1599</sup> However, if the Custodial Inspector considers that a matter raised by, or during, a mandatory or occasional inspection should be investigated, the Custodial Inspector may refer the matter to the Ombudsman or any other such person or body for investigation.<sup>1600</sup>

The Custodial Inspector is also entitled to visit or speak to a detainee at all reasonable times.<sup>1601</sup> The person in charge of a custodial centre, each member of staff of the custodial centre and any person providing services in a custodial centre must allow the Custodial Inspector (like the Commissioner for Children and Young People) to conduct an interview with a detainee out of the hearing of any other person, and must not, without approval of the detainee, copy, remove or read any correspondence between the detainee and the Custodial Inspector.<sup>1602</sup> These requirements are reflected in the Youth Justice Act.<sup>1603</sup>

The Custodial Inspector's 2020–21 annual report indicated that the Custodial Inspector held 'few concerns about the operations at [Ashley Youth Detention Centre]'.<sup>1604</sup>

Mr Connock told us that his many other responsibilities limited his ability to visit Ashley Youth Detention Centre.<sup>1605</sup> Mr Connock also indicated that the Office of the Custodial Inspector was 'not well enough resourced to do a full omnibus inspection most of the time', so it undertook themed inspections instead.<sup>1606</sup> The permanent staffing of the



Office of the Custodial Inspector is the Inspector, one Principal Inspection Officer, one Senior Inspection Officer and one Administration and Research Officer.<sup>1607</sup> Given the other demands on his time, the current Custodial Inspector has formally delegated all of his functions and powers under the Custodial Inspector Act to his staff.<sup>1608</sup>

In the Custodial Inspector's 2021–22 annual report, the Custodial Inspector noted that, despite receiving extra funding for the Administration and Research Officer position, the Inspectorate's resources were 'still limited'.<sup>1609</sup> He noted that, due to the departure of two staff members in late 2021 and difficulties in recruiting staff, there was a backlog of inspections.<sup>1610</sup> He also indicated that the Inspectorate was unlikely to meet its three-year legislative timeframe for inspecting all custodial centres against all standards.<sup>1611</sup>

The Custodial Inspector has prepared eight reports into Ashley Youth Detention Centre, covering the themes of health and wellbeing; education and programs; custody; families, communities and partnerships; equal opportunity; food and nutrition; resources and systems; and environmental health and hygiene.<sup>1612</sup> These reports were published between October 2018 and February 2022. They relate to inspections undertaken between May 2017 and February 2021.

There is only one reference to child sexual abuse in the Custodial Inspector's reports on Ashley Youth Detention Centre—in the 2019 *Custody Inspection Report*.<sup>1613</sup> That report referred to the National Royal Commission's recommendation that state and territory governments review legislation, policies and procedures to ensure best practice for personal searches. The Custodial Inspector's report recommended that the (former) Department of Communities consider 'best practice processes for conducting personal searches of young people including providing clear information, including illustrations, about how the search will be performed'.<sup>1614</sup> As discussed in Section 9.1.4, the Department updated its procedure for personal searches of children and young people in detention in February 2023.<sup>1615</sup>

In oral evidence, Mr Connock indicated that the standards related to safety, security and health would be particularly important for managing allegations of child sexual abuse.<sup>1616</sup>

The security standards refer to 'the importance of ensuring that the environments in which young people are lawfully detained are safe, secure, and developmentally appropriate'.<sup>1617</sup> They specify (among other matters) that:

- detention centres are to be adequately staffed at all times<sup>1618</sup>
- the use of force, including any form of restraints, should not cause humiliation or degradation and should be used for the shortest possible time (refer to Section 9.3)<sup>1619</sup>

- behaviour management schemes should have incentives to promote effort and good behaviour and use fair sanctions for poor behaviour (these schemes are discussed in Section 6.3)<sup>1620</sup>
- young people should be separated or segregated only in response to an unacceptable risk to themselves or others, and only when all other means of control have been exhausted (isolation is discussed in Section 9.2)<sup>1621</sup>
- young people, staff and visitors should understand that bullying and intimidating behaviour are not acceptable and be aware of the consequences of such behaviour.<sup>1622</sup>

The health and wellbeing standards ‘provide guidance to youth justice services about ways that optimise the health and wellbeing of young people’.<sup>1623</sup> They state that young people in custody should have their health needs addressed by appropriate health and ancillary services, and they should have a minimum of 10 hours out of their rooms each day.<sup>1624</sup>

We agree that these standards are relevant to ensuring an environment that protects children and young people from the risks of child sexual abuse. However, we consider that other standards are also relevant to minimising the risks of child sexual abuse in youth detention, such as the service delivery standard, which states that ‘young people in detention centres have the right to be safe and free from abuse’.<sup>1625</sup>

In oral evidence, Mr Connock told us that his office received ‘all sorts of internal documentation now’ about Ashley Youth Detention Centre, including ‘numbers about residents, where they’re housed [and] various incidents’.<sup>1626</sup> According to the Tasmanian Government’s most recent progress report on implementing the recommendations of the National Royal Commission, Ashley Youth Detention Centre has ‘implemented changes to ensure that the Custodial Inspector is notified of all significant incidents’ at the Centre.<sup>1627</sup> This is a positive development. However, it is not clear that the Custodial Inspector is resourced well enough to analyse or act on these reports.

Further, while we acknowledge the Custodial Inspector’s resourcing constraints, we consider that thematic inspections are less likely to identify abuse or mistreatment of children and young people in detention than full, open-ended inspections that take a broad view of children’s safety, health and wellbeing.

Chapter 11, Case study 1 reveals recollections of victim-survivors who said they had been sexually abused at Ashley Youth Detention Centre from the early 2000s to as recently as the early 2020s.<sup>1628</sup> In that case study, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. In Chapter 11, Case study 3, we find that the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today. While

the Custodial Inspector's 2019 *Custody Inspection Report* commented on the use of isolation, that report did not identify any abusive practices in relation to this issue.<sup>1629</sup>

In oral evidence, Mr Connock conceded he was unaware of the extent of the abusive practices at Ashley Youth Detention Centre and accepted that more needed to be done to empower children and young people experiencing sexual or other abuse to make complaints.<sup>1630</sup>

We acknowledge that, as outlined in Sections 10.1 and 11.2, many children and young people felt it was unsafe to raise concerns with oversight bodies about child sexual abuse at Ashley Youth Detention Centre for fear of reprisals or punishment from staff or other young people in detention. Nevertheless, we consider that a proactive oversight body should understand the risks of child sexual abuse in the institution it is overseeing and not accept the absence of reports of abuse as an indication that abuse is not occurring. Rather, as noted, an effective oversight body should treat low reporting rates in a high-risk institution as grounds for further action and investigation.

## 11.2 Experiences of children and young people

We heard evidence from children and young people in detention and former detainees that suggests that external oversight of youth detention has not been effective. We acknowledge that some of these experiences predate the creation of the statutory Commissioner for Children and Young People and the Custodial Inspector.

Some children and young people in detention or formerly in detention were unaware that they could ask an external entity for help. For example, Warren (a pseudonym), a victim-survivor who was first admitted to Ashley Youth Detention Centre in the mid-2000s when he was 13 years old, told us:

I didn't know if there was anyone outside Ashley we could make a complaint to. Now I know I can make a complaint to the Ombudsman but I didn't know that when I was at Ashley.<sup>1631</sup>

We also heard that where young people in detention did make a complaint, they did not receive effective responses from the oversight body in question, or faced negative repercussions from Ashley Youth Detention Centre staff for doing so. Erin, whose experiences we describe in Chapter 11, Case study 1, told us that the complaint she made to the Ombudsman about highly concerning sexual behaviour towards her from a male youth worker in 2012 was referred to the Centre and that the Ombudsman's Office did not contact her again.<sup>1632</sup> Erin said she was not notified of any outcome by the Department or the Ombudsman and said other staff were 'pissed off' at her for speaking up. Subsequently, she felt it was pointless to make a complaint.<sup>1633</sup>

As discussed in Chapter 11, Case study 6, when Counsel Assisting asked Max (a pseudonym), a victim-survivor who was detained at Ashley Youth Detention Centre, how he was treated by staff after speaking to the Commissioner for Children and Young People in the late 2010s, he said:

They treated me like shit. They weren't giving me any, like, toasties, they'd only give me drinks when I was allocated drinks. Like, before that they'd give us drinks sort of whenever, like toasties whenever, and then they just started just restricting everything. They tried to do it all by the rules, but like, they were just being real—they were just being real, like, real strict about everything, when they hadn't been like that, then after that they just started doing it.<sup>1634</sup>

When Counsel Assisting asked Max if he felt like he was being punished because he had spoken to the Commissioner for Children and Young People, he replied 'Yeah, yeah, it was obvious what they were doing'.<sup>1635</sup>

We did not ask the Tasmanian Government or the Commissioner for Children and Young People to give extensive evidence to reject or support Max's evidence. However, the Ashley Youth Detention Centre staff member against whom the allegation was made denied the allegation during hearings.<sup>1636</sup>

Children and young people consulted for the *Take Notice, Believe Us and Act!* report said they were aware that the Commissioner for Children and Young People could help them make complaints.<sup>1637</sup> However, some children and young people reported that they were not always allowed or encouraged to contact independent entities, while others noted that there were repercussions for doing so.<sup>1638</sup>

That's another thing that Ashley [Youth Detention Centre] hates as well. They put all these posters up and that, but deep down they hate it. If you say, 'I want to call the Commissioner,' they're just like, 'Oh, you're going to do that, are you?' Because most times people do it to complain about a certain staff member. And then that staff member doesn't do shit for you. They say, 'Well, if you call the Commissioner, then I'm not doing shit for you.' They're like, 'I'll give you what I have to, I'll give you your food and that, but only because I have to by law, but I'm not going to sit there and like you. If you do that, you're just a scumbag.' The amount of times I've had that said to me, then like, 'No, I'm only joking'.<sup>1639</sup>

In Section 4, we make recommendations aimed at transforming the culture in youth detention, including ensuring children and young people are aware of their rights, empowering them to speak up and ensuring staff in detention facilities comply with a professional conduct policy that specifies standards of acceptable behaviour. In Section 10.3, we recommend measures to encourage complaints and critical feedback in youth detention from children and young people, and staff.

We also consider that there is scope to strengthen Tasmania's system of external oversight for youth detention.

## 11.3 A new Commission for Children and Young People

In Chapter 18, we set out our recommendations to establish a new, independent Commission for Children and Young People that would subsume the functions of the current Commissioner for Children and Young People and have additional functions (Recommendation 18.6). These would include regulatory functions under the Child and Youth Safe Organisations Act in relation to the Child and Youth Safe Standards and the Reportable Conduct Scheme.

The new Commission for Children and Young People would have three statutory officeholders, each appointed by the Governor for a term not exceeding five years:

- a Commissioner for Children and Young People, who would also be the Independent Regulator under the Child and Youth Safe Organisations Act
- a Commissioner for Aboriginal Children and Young People (discussed in Chapter 9)
- a Child Advocate (Deputy Commissioner) (discussed in Chapter 9).

To be effective, a youth detention oversight body should have expertise in relation to children and be independent—in its composition, resources, legal status and powers—of the institutions or agencies it is responsible for overseeing.<sup>1640</sup> As discussed in Section 11.1.1, we heard evidence that cast doubt on the ability of the role of Commissioner for Children and Young People to be performed independently and effectively.

To maximise the independence of the new Commission for Children and Young People, we recommend in Chapter 18 that:

- Commissioners for Children and Young People and Deputy Commissioners be appointed following an externally advertised merit-based selection process to ensure they have relevant professional qualifications and substantive experience in matters affecting children (Recommendation 18.7)
- before making a recommendation to the Governor for an appointment to the Commission for Children and Young People, the Minister be required to consult with the leader of any political party that has at least two members in either house of Parliament (Recommendation 18.7)
- the Commission for Children and Young People be separately and directly funded, like the Ombudsman, rather than through the Department for Education, Children and Young People (Recommendation 18.8)
- the performance of the functions of the Commission for Children and Young People be monitored by a joint standing committee of the Tasmanian Parliament (Recommendation 18.9).

The new Commission for Children and Young People would not be a general complaints-handling or investigation body but would have a new individual advocacy function for children in out of home care and youth detention through a new independent community visitor scheme, and functions and powers to monitor the out of home care and youth justice systems (refer to Chapter 9 and the discussion in Sections 11.4 and 11.6 of this chapter).

## 11.4 Strengthening individual advocacy for children in detention

It is vital that children and young people in youth detention are supported to express any concerns about their treatment and that those concerns are treated confidentially.<sup>1641</sup> It is also essential that such support remains in place until those concerns are resolved. The South Australian Guardian for Children and Young People, Penny Wright, told us that, despite not having a direct complaints-handling function for children in youth detention, her office's most important mechanisms for protecting children in detention against the risk of sexual abuse were regular visits to detention facilities, regular sighting of all children in detention and the opportunity for children to speak to advocates confidentially.<sup>1642</sup>

As noted, the Commissioner for Children and Young People also has an individual advocacy function for children and young people in detention, which involves the Commissioner regularly engaging with children in detention and providing them with an opportunity to speak with advocates confidentially. While we consider that this function could be strengthened, we acknowledge that the performance of the Commissioner's advocacy role has been enhanced since the appointment of a fixed-term dedicated Advocate for Young People in Detention in the office of the Commissioner for Children and Young People (noted in Section 11.1.1).<sup>1643</sup>

We heard evidence about the operation of independent community visitor schemes in Queensland and Victoria.<sup>1644</sup> The Queensland scheme applies to children in out of home care and youth detention, while the Victorian scheme only applies to children in youth detention centres.<sup>1645</sup> We also heard from Ms Wright about her role as Training Centre Visitor.<sup>1646</sup> We were impressed by the capacity of these mechanisms to identify issues of concern to children and young people in detention—including concerns about child sexual abuse—and to effectively advocate on behalf of children and young people in detention for the resolution of their concerns.

In Chapter 9, we recommend that the Tasmanian Government introduces legislation to establish an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities, based on the Queensland Community Visitor Program (Recommendation 9.34). The key features of that program, which is administered by the Queensland Public Guardian, are:

- Community visitors are appointed for up to three years by the Public Guardian.<sup>1647</sup> They must have the ‘knowledge, experience or skills needed’ to perform the functions of the role.<sup>1648</sup> They are not volunteers and are not employees of the public service.<sup>1649</sup>
- Community visitors have a range of statutory functions, including developing a trusting and supportive relationship with each child they visit, advocating on behalf of the child, inspecting detention centres, and ensuring the child’s needs are being met.<sup>1650</sup>
- Community visitors must visit children in detention ‘regularly’.<sup>1651</sup> One Queensland youth detention centre is visited twice a week, while the remaining two are visited weekly.<sup>1652</sup> A child in detention can also request a visit from a community visitor.<sup>1653</sup>
- Community visitors have various statutory powers, including the power to enter a detention centre without notice, inspect the centre, talk to a child in private and require a staff member to answer questions and produce documents.<sup>1654</sup>

In Chapter 9, we also recommend that the independent community visitor scheme be administered by the new Commission for Children and Young People and led by the new Child Advocate. The Child Advocate should be responsible for appointing community visitors based on their skills, knowledge and expertise, including in the areas of child development, working with vulnerable children and young people, and the experiences and needs of Aboriginal children and young people. The Child Advocate should appoint at least one independent community visitor who is Aboriginal.

In relation to youth detention, we consider that community visitors should be responsible for:

- developing trusting and supportive relationships with children and young people in detention and assisting them to understand their rights
- advocating on behalf of children and young people in detention by listening to, giving voice to and helping to resolve their concerns and grievances
- facilitating access to support services for children and young people in detention
- inquiring into and reporting on the physical and emotional wellbeing of children and young people in detention
- inquiring into whether the needs of children and young people in detention are being met
- conducting exit interviews with children and young people leaving detention.



The independent community visitor scheme should be funded to enable every child and young person in detention to be visited weekly or whenever a child requests a visit. Ideally, a child would be visited by the same visitor each week, to build a relationship of trust. Children and young people in other residential youth justice facilities, such as the proposed assisted bail facilities (discussed in Section 5.4.5) and supported residential facilities (discussed in Section 6.8.2), should also receive regular visits.

Aboriginal children in detention should have access, wherever possible, to an independent community visitor who is Aboriginal. Alternatively, an Aboriginal child or young person in detention may request the involvement or assistance of the Commissioner for Aboriginal Children and Young People. Where such a request is made, the Child Advocate should work closely with the Commissioner for Aboriginal Children and Young People to arrange this.

We also consider that a child or young person who is transferred from youth detention to adult prison before they turn 18 should continue to receive visits from an independent community visitor until they turn 21. This will ensure continuity of the relationship between the visitor and the child or young person and recognise the increased vulnerability to sexual abuse of children and young people in prison.

Interviews between independent community visitors and young people in detention should be conducted in a safe environment, and out of the hearing and sight of detention centre staff and other young people to ensure privacy and confidentiality.<sup>1655</sup> We heard evidence that, occasionally, the environment at Ashley Youth Detention Centre was not always safe for discussions with oversight bodies. Commissioner McLean told us that, during periods when the Centre was under restrictive practices or lockdowns (discussed in Sections 4.7.2 and 9.2.2), she had to conduct advocacy through the door of children and young people's rooms:

My understanding today is that we have moved back to restrictive practices, that young people may be cycling in and out of their rooms on an hourly basis ... When you visit the facility to speak to young people and advocate for them through a small window hole in the door, it is really awful ... I don't think it would meet the safety requirements of the centre for a worker, because they're so thin on the ground, to come off the floor to supervise a young person out of their room to engage with the Commissioner or the Advocate.<sup>1656</sup>

We also heard that phone calls at Ashley Youth Detention Centre are monitored and are within a sight line of a youth worker.<sup>1657</sup> We heard that a phone with prerecorded numbers had been installed at Ashley Youth Detention Centre, but these did not include the numbers of all oversight bodies.<sup>1658</sup>

In 2019, the Custodial Inspector observed that, for a phone call to be made from Ashley Youth Detention Centre, a child or young person needed to ask a staff member to provide a phone, which would then be plugged into a connection point on the wall.<sup>1659</sup>

In some units, such points were available in rooms separate from the common area; however, the Custodial Inspector noted that sound travelled around these rooms and ‘little privacy [was] afforded for the young person making the call’.<sup>1660</sup> In other units, the only phone connection point was in the common area, which provided ‘no privacy whatsoever’.<sup>1661</sup> The Custodial Inspector recommended that the then Department of Communities consider:

... options for installing private spaces with appropriate confidential settings in each unit at [Ashley Youth Detention Centre] for young people to make professional and personal telephone calls.<sup>1662</sup>

The Tasmanian Government’s most recent annual Action Plan in response to the recommendations of the National Royal Commission states that:

... all children and young people detained at [Ashley Youth Detention Centre] can contact the [Commissioner for Children and Young People] by telephone at any time, in a physical location that offers the detainees increased privacy.<sup>1663</sup>

As noted in Section 6.7.4, in June 2023, the Department informed us that it had ‘recently procured mobile phones for young people within Ashley Youth Detention Centre’, which would give them ‘the ability to make personal and professional calls from the privacy of their bedrooms or the Centre’s outside spaces or meeting rooms, outside of school hours’.<sup>1664</sup> The mobile phones were expected to be provided to children and young people in July 2023.<sup>1665</sup> We welcome this initiative because it is essential that children and young people be able to make private phone calls, including to oversight bodies.

In Chapter 9, we recommend that the independent community visitor scheme includes funding for a small number of legally trained child advocacy officers—also appointed by the Child Advocate—to help children and young people in out of home care and youth detention with more complex concerns. These officers could assist children and young people in detention to make a formal complaint to the Ombudsman, where the concern cannot not be resolved informally. The Ombudsman’s processes are discussed in Section 11.5.

## Recommendation 12.36

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

- a. independent community visitors visit children and young people in detention facilities weekly, at a minimum
- b. Aboriginal children and young people in detention or other residential youth justice facilities have access, wherever possible, to visits from an Aboriginal independent community visitor or from the Commissioner for Aboriginal Children and Young People, depending on the child’s preference

- c. independent community visitors have the necessary statutory powers to perform their functions, including the power to enter the facility, have access to children and young people in the facility and inspect the facility
- d. each facility where children and young people are detained or reside has a safe, dedicated space where independent community visitors can meet with children and young people and discuss concerns without being observed or overheard by staff or other children and young people.

## 11.5 Complaints to the Ombudsman about children's experiences in detention

From 1 January 2024, under the Child and Youth Safe Organisations Act, complaints about child sexual abuse and related matters against staff in youth detention will constitute a 'reportable allegation' and fall within the scope of the Reportable Conduct Scheme. If the Ombudsman's Office received such a complaint, it should be able to share this information with the Independent Regulator of the scheme, so a reportable conduct investigation can be undertaken (refer to Chapter 18 for a discussion of information sharing between oversight bodies).

For complaints about administrative actions or departmental decisions, such as the placement of a child or young person in a particular unit in a detention facility, we consider that the Ombudsman is the appropriate body to continue to receive such complaints, rather than the new Commission for Children and Young People. However, there is scope to improve the Ombudsman's processes.

Currently, a complaint to the Ombudsman must be made by the person who is 'personally aggrieved' by the administrative action, unless that person has died or cannot act for themselves, in which case the complaint may be made by a personal representative suitable to represent them.<sup>1666</sup> We heard from Mr Connock that if a child or young person has the capacity and wants to make a complaint, then 'it should probably come from the young person, but we would treat everything on a case-by-case [basis]'.<sup>1667</sup>

In Chapter 9, we recommend that the new Child Advocate be given the power to make a complaint to the Ombudsman on behalf of a child in out of home care, youth detention or another residential youth justice facility (Recommendation 9.35). In that chapter, we also propose that the Office of the Ombudsman works with the new Commission for Children and Young People to establish an accessible, child-friendly complaints process and develop specialisation among investigators in managing complaints from or involving children in out of home care, youth detention or other residential youth justice facilities.

In Chapter 18, we recommend that the Ombudsman, the Commission for Children and Young People, the Integrity Commission and the Registrar of the Registration to Work with Vulnerable People Scheme develop a memorandum of understanding relating to the management of reports, complaints and concerns about child sexual abuse (Recommendation 18.15). This memorandum of understanding should provide for permissive information-sharing practices that prioritise the safety of children. We discuss this recommendation in Section 11.8 of this chapter.

In Chapter 18, we also recommend that the Ombudsman, the Commission for Children and Young People, the Integrity Commission and the Registrar of the Registration to Work with Vulnerable People Scheme work jointly to develop a user-friendly guide for the general public that describes (among other matters):

- how each of these agencies can assist with complaints and concerns about how organisations respond to child sexual abuse
- the process they will adopt to respond to reports, complaints and concerns
- how information provided by a person lodging a report, complaint or concern will be shared and managed
- how agencies are committed to a ‘no wrong door’ approach to complaints, so people are reassured that all reports, complaints and concerns will receive a response from an agency (Recommendation 18.14).

We also recommend that a child-friendly version of this guide be developed and publicised widely in youth justice, out of home care and health settings and schools. Both guides should be available on the agencies’ websites and form part of their child safety community education and engagement activities.

To improve the Ombudsman’s internal processes, we recommend that it develops guidelines for its staff on managing complaints involving child sexual abuse in youth detention, other residential youth justice facilities or out of home care.

### **Recommendation 12.37**

The Ombudsman should develop written guidelines for its staff on managing complaints it receives containing allegations of child sexual abuse involving children in youth detention, other residential youth justice facilities or out of home care.

Among other matters, these guidelines should include:

- a. the definition of child sexual abuse and related conduct, including sexual misconduct, grooming, harmful sexual behaviours and boundary breaches

- b. the process for reporting relevant allegations to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*
- c. guidance on referring an allegation or complaint to an agency named in the complaint
- d. guidance on communicating with child complainants on the referral of their complaints to other entities and the progress of investigations into their complaints
- e. processes for sharing information with other oversight bodies regarding the management of complaints (Recommendation 18.15).

## 11.6 Systemic monitoring of youth detention

The Custodial Inspector is responsible for inspecting and monitoring Tasmania's custodial centres. As such, the Custodial Inspector is not focused solely on youth detention and does not have specialist expertise in children or the youth justice system. To date, the Custodial Inspector has not identified any specific risks of child sexual abuse in Ashley Youth Detention Centre, even though such risks have clearly existed.

Mr Connock, the current Custodial Inspector, holds six other statutory roles and has limited capacity to devote to inspecting Ashley Youth Detention Centre. We received evidence that the Office of the Custodial Inspector is under-resourced.<sup>1668</sup> We are concerned that the current system for monitoring youth detention is ill-equipped to identify or prevent risks of child sexual abuse to children and young people in detention.

In our view, the oversight body responsible for systemic monitoring of youth detention should be child-focused and should specialise in working with children and young people. It should have expertise in child trauma and in preventing and identifying child sexual abuse.<sup>1669</sup> It should be resourced to engage in regular and frequent monitoring of youth detention facilities.

In Victoria, the Commission for Children and Young People has functions in relation to 'vulnerable children and young persons'.<sup>1670</sup> These include children and young people detained in a youth justice centre or a youth residential centre under the *Children, Youth and Families Act 2005 (Vic)* and children involved in the youth justice system more broadly.<sup>1671</sup> One of these functions is to 'monitor and report to Ministers on the implementation and effectiveness of strategies relating to the safety or wellbeing of vulnerable children and young persons'.<sup>1672</sup>

According to its 2021–22 annual report, the Victorian Commission for Children and Young People monitors the safety and wellbeing of children and young people in Victoria’s two youth justice centres. It does this by reviewing all serious incidents (such as assaults or self-harm) that occur in those centres, by conducting onsite inspections and by monitoring custodial population data and incident trends. It also tracks the use of isolation, force and restraints.<sup>1673</sup> The Victorian Commission for Children and Young People operates an independent visitor program for children and young people in youth justice centres and conducts exit interviews with children and young people leaving youth justice centres.<sup>1674</sup>

The Victorian Commission for Children and Young People also has specific inquiry powers in relation to children in youth detention. For example, it has a systemic inquiry power that enables it to conduct an inquiry into the provision of youth justice services to vulnerable children if it identifies a persistent or recurring systemic issue in the provision of those services and considers that a review will improve those services.<sup>1675</sup> In 2021, the Victorian Commission for Children and Young People published its *Our Youth, Our Way* inquiry report on the over-representation of Aboriginal children and young people in Victoria’s youth justice system (discussed in Section 7).<sup>1676</sup> That inquiry was conducted using the Commission for Children and Young People’s systemic inquiry power.<sup>1677</sup>

The Victorian Commission for Children and Young People can also conduct an inquiry into the safety and wellbeing of a vulnerable child or group of vulnerable children, where the inquiry relates to the services provided or omitted to be provided to that child or group of children.<sup>1678</sup>

Similarly, the Northern Territory Children’s Commissioner has the power to undertake investigations into systemic issues in youth detention under Part 5 of the *Children’s Commissioner Act 2013* (NT).<sup>1679</sup> In 2021–22, the Children’s Commissioner used its own-motion investigation powers to conduct preliminary inquiries into the detention of children under the age of 14 years in the Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.<sup>1680</sup> The Children’s Commissioner also has the power to inquire into the services provided to an individual child in youth detention.<sup>1681</sup>

In Tasmania, Commissioner McLean told us that she is provided with data about children and young people held at Ashley Youth Detention Centre, including the daily roll, minutes of Weekly Review Meetings and monthly reports of incidents, isolation, use of force and searches.<sup>1682</sup> She conceded that her office is constrained in its ability to analyse this data in significant detail due to a lack of resources.<sup>1683</sup> Commissioner McLean also referred to her role in advocating for a therapeutic approach to youth justice and noted that she had observed a strong emphasis on a shift to a therapeutic model since she started in the role.<sup>1684</sup>

We consider that the new Commission for Children and Young People, as an oversight body dedicated exclusively to issues relating to children and young people, should be

given functions and powers to monitor the wellbeing of children and young people in detention and the youth justice system more broadly. The Commission for Children and Young People should have expertise in working with vulnerable children and a deep understanding of the many challenges faced by children and young people in detention.

Giving the new Commission for Children and Young People systemic monitoring functions for youth detention would be complemented by the proposed independent community visitor scheme (refer to Recommendation 12.36). Through this scheme, the concerns expressed to visitors by children and young people in detention during regular visits would provide early and valuable insight into any systemic problems arising in youth detention centres.<sup>1685</sup>

This recommendation would also be consistent with our recommendation in Chapter 9 to give the Commission for Children and Young People expanded powers and resources to oversee and monitor the out of home care system. As noted in that chapter and in Section 5.5.3 of this chapter, many children in detention are also involved in the out of home care system—we consider it logical and appropriate for a single oversight body to monitor the experiences of these vulnerable children.

The Commission for Children and Young People should also have the power to enter adult prisons to monitor the safety and wellbeing of children and young people in those facilities. This is essential because of the increased vulnerability of children and young people to sexual abuse in prison.

We acknowledge that implementing these recommendations will require additional resourcing for the new Commission for Children and Young People. However, we consider that this is essential to ensure that a body with the necessary specialisation and expertise is responsible for systemic monitoring of youth detention.

Systemic monitoring by the Commission for Children and Young People should replace the inspection and monitoring of youth detention centres currently undertaken by the Custodial Inspector. However, the Tasmanian Government should consider whether the Commission for Children and Young People should assume responsibility for maintaining and reviewing the *Inspection Standards for Youth Custodial Centres in Tasmania* or whether they should remain the responsibility of the Custodial Inspector, given the Custodial Inspector will continue to be responsible for the standards for adult custodial facilities. If the Custodial Inspector retains responsibility for the youth detention standards, the Office of the Custodial Inspector should liaise with the new Commission for Children and Young People in updating and maintaining the standards.



## Recommendation 12.38

The Tasmanian Government should ensure the Commission for Children and Young People (Recommendation 18.6):

- a. has functions and powers to monitor the operation of youth detention centres and other residential youth justice facilities, and the safety and wellbeing of, and the provision of services to, children and young people in detention, and in the youth justice system more broadly, by
  - i. regularly monitoring and reviewing custodial population data and information on serious or adverse incidents (such as child sexual abuse, assaults, attempted suicide, self-harm, riots, escapes and property damage) and the use of isolation, force, restraints and searches
  - ii. conducting regular onsite inspections of youth detention and other residential youth justice facilities
  - iii. conducting own-motion systemic inquiries into issues that are identified through monitoring
  - iv. conducting own-motion inquiries into the youth justice services received by an individual child or group of children
- b. has the power to enter adult prison facilities to visit children and young people in those facilities to monitor their safety and wellbeing
- c. is adequately resourced on an ongoing basis to fulfil its systemic monitoring functions.

## 11.7 Appointing a child-specific National Preventive Mechanism

As noted in Chapter 10, Australia is a party to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT'), which it ratified in 2017.<sup>1686</sup>

Article 3 of OPCAT contains an obligation on States Parties to set up, designate or maintain, at the domestic level, one or several visiting bodies for preventing torture and other cruel, inhuman or degrading treatment or punishment, known as the National Preventive Mechanism.<sup>1687</sup> The key functions of the National Preventive Mechanism are to visit and inspect places of detention, and to provide advice and make recommendations to the State to prevent torture and cruel, inhuman or degrading treatment.<sup>1688</sup>

Article 17 of OPCAT requires States Parties to maintain, designate or establish the National Preventive Mechanism no later than one year after ratification of the protocol.<sup>1689</sup> Australia sought to delay its obligation to establish a National Preventive Mechanism, with 20 January 2023 set as the date for compliance.<sup>1690</sup>

OPCAT also requires States Parties to facilitate visits by the United Nations Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Subcommittee on Prevention').<sup>1691</sup> The Subcommittee on Prevention comprises 25 independent human rights experts who serve in their personal capacity and monitor States Parties' adherence to OPCAT.<sup>1692</sup>

The National Royal Commission recommended that the National Preventive Mechanism(s) be provided with:

... the expertise to consider and make recommendations relating to preventing and responding to child sexual abuse as part of regularly examining the treatment of persons deprived of their liberty in places of detention.<sup>1693</sup>

In October 2022, the Australian Human Rights Commission published a 'road map' to compliance with OPCAT.<sup>1694</sup> This followed a national symposium in September 2022 that brought together relevant stakeholders from the Australian, state and territory governments.<sup>1695</sup> That document recommended that governments ensure National Preventive Mechanisms are designed and operate in a way that reflect the needs of vulnerable cohorts who are disproportionately represented in places of detention.<sup>1696</sup>

The Tasmanian Parliament passed the *OPCAT Implementation Act 2021* in November 2021. The purpose of the Act is to enable the National Preventive Mechanism to be appointed and maintained, and for the Subcommittee on Prevention to fulfil its mandate as set out in OPCAT.<sup>1697</sup> Significantly, the Act provides for the appointment of 'a person, or more than one person' as a Tasmanian National Preventive Mechanism.<sup>1698</sup>

The functions of the Tasmanian National Preventive Mechanism include:

- regularly examining the treatment of people deprived of their liberty in places of detention, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment
- requiring the provision of, or access to, information held by any person concerning detainees, including the number and treatment of detainees
- accessing, inspecting and reviewing places of detention
- interviewing detainees
- making recommendations and providing advice to the relevant authorities, to improve the treatment and conditions of people deprived of their liberty and prevent torture and other cruel, inhuman or degrading treatment or punishment
- developing and publishing guidelines and standards in respect of detainees or places of detention.<sup>1699</sup>

In February 2022, the Tasmanian Government announced that Richard Connock had been appointed to the position of a Tasmanian National Preventive Mechanism for two years.<sup>1700</sup>

In the Ombudsman's 2021–22 annual report, Mr Connock referred to his appointment as a Tasmanian National Preventive Mechanism and indicated that he was not required to report publicly on the performance of these functions.<sup>1701</sup> He also stated that 'little work' has been undertaken by the Australian, state and territory governments to progress implementation of OPCAT—for example, to establish monitoring standards—which 'renders the making of [a National Preventive Mechanism] office Budget Submission impossible at present'.<sup>1702</sup>

The Ombudsman's annual report also observed that implementing the National Preventive Mechanism would require 'significant resourcing and funding'.<sup>1703</sup> Mr Connock reiterated during our hearings that this additional appointment constituted a further stretching of his capacity, explaining that 'with OPCAT I've now got seven jurisdictions, and it's becoming increasingly difficult to keep track of everything'.<sup>1704</sup>

The Subcommittee on Prevention suspended a visit to Australia in October 2022 after it was unable to gain unrestricted access to all places of deprivation of liberty in Queensland and New South Wales.<sup>1705</sup> Subsequently, it announced that it had decided to terminate its suspended visit to Australia.<sup>1706</sup> However, before the visit to Australia was suspended, the Subcommittee on Prevention visited Ashley Youth Detention Centre.<sup>1707</sup> In February 2023, the Subcommittee on Prevention indicated that it would share a report with the Australian Government on what was observed during its October visit 'as soon as possible'.<sup>1708</sup> The Australian Government has not disclosed whether it will release the report publicly.

We note that other jurisdictions have appointed multiple National Preventive Mechanisms for different detention contexts.<sup>1709</sup> In the Northern Territory, the Office of the Children's Commissioner has been proposed (though not yet appointed) as a child-specific National Preventive Mechanism, alongside the Northern Territory Ombudsman.<sup>1710</sup>

Given Mr Connock's many statutory roles, we consider that there would be considerable benefit in the Tasmanian Government appointing another National Preventive Mechanism with expertise in children and young people to focus on examining facilities where children and young people are detained. Given our recommendation to transfer systemic monitoring functions for youth detention from the Custodial Inspector to the new Commission for Children and Young People (Recommendation 12.38), we also recommend appointing this body as a Tasmanian National Preventive Mechanism for children and young people. The two National Preventive Mechanisms should work together closely.

We acknowledge that a small number of children may be sentenced to adult imprisonment, or may be transferred from youth detention to adult prison, and that the Commission for Children and Young People will not be a body with general expertise in the adult correctional system. Despite this, we consider that the significant number of children in youth detention who are also involved in the out of home care system makes the new Commission—a body with responsibility for monitoring the out of home care and youth justice systems—an appropriate National Preventive Mechanism for children and young people.

According to Article 18 of OPCAT, States Parties must ‘guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel’. To achieve this, the Commission for Children and Young People’s National Preventive Mechanism function should be funded and resourced separately from its other functions.

### **Recommendation 12.39**

The Tasmanian Government should:

- a. appoint the Commission for Children and Young People (Recommendation 18.6) as an additional National Preventive Mechanism under the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), with expertise in child rights, child trauma, the prevention and identification of child abuse, the needs of Aboriginal children and young people and the needs of children and young people with disability, and with power to inspect places where children and young people are detained
- b. resource Tasmanian National Preventive Mechanisms sufficiently to allow them to effectively fulfil their functions under OPCAT.

## **11.8 Collaboration among oversight bodies**

As discussed in Chapter 18, effective information sharing is a crucial part of any child-centred system to ensure oversight bodies are clear about their respective roles and responsibilities in responding to any concerns about child safety. A child (or their advocate) should be able to make a complaint to, or raise a concern with, any of these oversight bodies and have it actioned or redirected appropriately without the child or young person needing to understand which type of complaint or concern should be raised with which body.

In Chapter 18, we describe the evidence we heard from Commissioner McLean, Mr Connock and Michael Easton, Chief Executive Officer, Integrity Commission, about the way the Commissioner for Children and Young People, Ombudsman and Integrity Commission work together on matters concerning children and young people. We heard that there are no consistent formal arrangements for information sharing or clear roles and responsibilities between these entities, with the determination of who is best placed to deal with a complaint often managed on a case-by-case basis.<sup>1711</sup>

In discussing the information-sharing relationship between these entities, Mr Connock said:

So, while there's no protocol or memorandum of understanding, we all have a high level of understanding of our various functions ... As the Commissioner has said, she doesn't have the individual complaint-handling thing, but our two offices have a really good relationship, I think, and a good understanding, and we will take the complaint if it's within our jurisdiction.<sup>1712</sup>

Commissioner McLean noted that if a child or young person wanted to make a complaint, she would assist them to make that complaint to the Ombudsman.<sup>1713</sup> However, she indicated that there had been times when she had been unclear about whether a particular complaint would constitute a matter over which the Ombudsman had jurisdiction:

And it's those good relations that we have with [Mr Connock] and his office that clear that up. I largely agree with what [Mr Connock] has said in that regard; there are no formal arrangements.<sup>1714</sup>

Commissioner McLean also indicated that there were no formal arrangements for sharing outcomes of individual cases referred to the Ombudsman:

So, we don't have a formal record-keeping system in that regard, but we do check in with young people very regularly, including whether or not they have heard about the progress of their complaint.<sup>1715</sup>

Subsequently, in August 2022, Commissioner McLean told us that her office had negotiated an information-sharing arrangement with the Ombudsman's Office, noting that it can be confusing for children and young people to determine the responsible oversight body:

... I acknowledge that it can be a bit confusing for young people and we often find ourselves in that explanatory position and saying, 'Look, we're not going to handle this complaint but we will make sure that the Ombudsman gets the complaint'. And just recently between the Ombudsman's Office and our office we have negotiated an information-sharing arrangement that, with the use of a consent form, enables information about the outcome of the complaint to also come through my office so that we can help to communicate the outcome of the complaint to the young person.<sup>1716</sup>

We do not consider that relying on goodwill between oversight bodies is sufficient to protect the rights of vulnerable children and young people. We commend the information-sharing arrangement that has been agreed between the Commissioner for Children and Young People and the Ombudsman.

No child or young person should be turned away from an oversight body; rather, an oversight body that is approached by a child or young person should determine where they will receive the most appropriate assistance.

We consider that establishing the independent community visitor scheme for children and young people in detention (refer to Recommendation 12.36) will go a considerable way to ensuring children and young people feel confident to raise concerns about their treatment in detention, are aware of their rights, and understand the roles of the various oversight bodies and the process for making a formal complaint. As outlined in Section 11.4, independent community visitors would be responsible for assisting children and young people in detention to raise concerns and make complaints, and would keep children and young people informed of the progress of these matters.

Also, as noted in Chapter 18, we consider that there would be benefit in oversight bodies developing clear and formalised information-sharing agreements to underpin their practices. This is particularly important considering the new Commission for Children and Young People's recommended oversight functions and powers in relation to Child and Youth Safe Standards and the Reportable Conduct Scheme.

In that chapter, we recommend that the Commission for Children and Young People, the Integrity Commission, the Ombudsman and the Registrar of the Registration to Work with Vulnerable People Scheme develop a formal memorandum of understanding for managing and overseeing reports, complaints and concerns relating to child sexual abuse that:

- defines the roles, responsibilities, functions and limitations of each agency and describes where these overlap or intersect
- requires consultation prior to the initiation of systemic reviews or inquiries where the subject of that inquiry relates to areas of common interest or intersecting functions
- provides for permissive and enabling information-sharing practices that prioritise the safety and welfare of children for individual matters and ensure each party receives from others de-identified trend data necessary to perform its functions (Recommendation 18.15).

## 12 Conclusion

We remain gravely concerned about the culture at Ashley Youth Detention Centre and the safety and wellbeing of the children and young people detained there.

Children in detention are among the most vulnerable children in the community. Many have experienced violence, abuse, neglect and trauma, and have been failed by multiple service systems—education, health, housing and child protection—before coming into contact with the criminal justice system. The detention system must not harm them further. It must keep them safe from sexual abuse. It must also provide the children in its care with the support they need to turn their lives around.

In this chapter, we have described the extensive reforms needed to divert children from detention wherever possible and to create a child safe culture in youth detention—a culture where children are aware of their rights, they are listened to, their views are taken into account, and their rights are respected. Implementing these reforms will require strong leadership, a long-term commitment to change from all involved, and staff who have the right attributes and skills to build constructive and therapeutic relationships with children in detention. Resistance to change among staff must be overcome to achieve meaningful reform.

Implementation of our recommendations will also require a genuine commitment to listening to the voices of children in detention and those with experience of detention and, in particular, to the voices of victim-survivors of child sexual abuse in detention.

We acknowledge that reform of youth detention and the youth justice system is a monumental task. Those responsible for implementation will face challenges and setbacks. We agree with the Northern Territory Royal Commission that:

Progress is not always linear, especially during a process of major reform and when dealing with a vexed social issue such as young people who have offended. Critics of the system may seize on these moments to discredit it, but they are both normal and inevitable. They are not a reason to abandon the change. The leaders of the reform should acknowledge the possibility that missteps will occur ... The test for those administering the system and their leaders is how they respond to challenges when they arise.<sup>1717</sup>

We urge the Tasmanian Government and future governments to maintain the commitment to implementing our recommendations to ensure the safety of Tasmanian children in youth detention and the youth justice system.



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- 496 *Youth Justice Act 1997* s 10(2).
- 497 *Youth Justice Act 1997* s 9(2), (3), (5).
- 498 *Youth Justice Act 1997* s 9(2)(c).
- 499 *Youth Justice Act 1997* s 11(1), (2). As noted in Section 7.1, we are not aware of any recognised Aboriginal organisations having been declared for the purposes of the *Youth Justice Act 1997*. Under section 12(1) of the *Youth Justice Act 1997*, if a formal caution is to be administered to a child or young person who is 'a member of a religious, ethnic or other community group' and the authorised police officer who would otherwise administer the formal caution considers it appropriate, the caution may be administered by a representative of that group approved by that authorised police officer.
- 500 *Youth Justice Act 1997* s 10(2).
- 501 *Youth Justice Act 1997* s 10(3)(b), (10).
- 502 *Youth Justice Act 1997* s 10(3)(b).
- 503 *Youth Justice Act 1997* s 9(4).
- 504 *Youth Justice Act 1997* ss 13(1), 14(2), 15.
- 505 *Youth Justice Act 1997* s 14(2)(c)(ii).
- 506 *Youth Justice Act 1997* ss 16(1), 17.
- 507 *Youth Justice Act 1997* s 16(1).
- 508 *Youth Justice Act 1997* s 20(1).
- 509 Productivity Commission, *Report on Government Services* (Report, 31 January 2023) part C, section 6, table 6A.9.
- 510 Productivity Commission, *Report on Government Services* (Report, 31 January 2023) part C, section 6, table 6A.9.
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- 512 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 45. The Sentencing Advisory Council reported a slight increase in the number of formal cautions over this period.



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- 516 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 45–46.
- 517 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 45.
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- 520 Noetic Solutions Pty Ltd, *Custodial Youth Justice Options Paper: Report for the Tasmanian Government Department of Health and Human Services* (Report, October 2016) 15.
- 521 Tasmania Legal Aid, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (undated) 11.
- 522 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 51.
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- 525 Department for Education, Children and Young People, *Draft Youth Justice Blueprint 2022–2032 Keeping Children and Young People out of the Youth Justice System* (Draft Report, 3 February 2023) 11, 19.
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- 528 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 15.
- 529 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 15–16.
- 530 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 15.
- 531 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 16.
- 532 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 5.
- 533 Kamarah Pooley, *What Are the Characteristics of Effective Youth Offender Programs?* (Australian Institute of Criminology Trends & Issues in Crime and Criminal Justice No. 604, September 2020) 12.
- 534 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 44.
- 535 *Justices Act 1959* s 34.
- 536 *Criminal Law (Detention and Interrogation) Act 1995* s 4.
- 537 Tasmanian Government, Department of Justice, 'Reforms to the Tasmanian Bail System' (Position Paper, January 2018) 20.
- 538 *Youth Justice Act 1997* s 25(2).
- 539 Australian Institute of Health and Welfare, *Youth Justice in Australia 2021–22* (Report, 31 March 2023) Table S109a. The Australian Institute of Health and Welfare advises that '[t]his data should be interpreted with caution due to potential issues with recording and updating of custodial order details in Tasmania'.
- 540 Transcript of Fiona Atkins, 24 August 2022, 3273 [2–3].
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- 542 Australian Institute of Health and Welfare, *Youth Justice in Australia 2021–22* (Report, 31 March 2023) Table S109a.

- 543 Australian Institute of Health and Welfare, *Youth Justice in Australia 2021–22* (Report, 31 March 2023) Table S117. The Australian Institute of Health and Welfare advises that '[t]his data should be interpreted with caution due to potential issues with recording and updating of custodial order details in Tasmania'.
- 544 Commissioner for Children and Young People, *Procedural Fairness Response*, 15 June 2023, 4.
- 545 Tasmania Legal Aid, *Children First: Children in the Child Safety and Youth Justice System* (Report, July 2021) 18.
- 546 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 95.
- 547 Sentencing Advisory Council Victoria, *Children Held on Remand in Victoria: A Report On Sentencing Outcomes* (Report, September 2020) 5.
- 548 Transcript of Robert White, 18 August 2022, 2798 [46]–2799 [1].
- 549 Statement of Vincenzo Caltabiano, 13 July 2022, 5 [28].
- 550 Tasmania Legal Aid, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (undated) 13. These issues were also identified in a 2013 report of the former Acting Commissioner for Children: Acting Commissioner for Children Tasmania, *Alternatives to Secure Youth Detention in Tasmania* (Report, 26 July 2013) 86–87.
- 551 Transcript of Hannah Phillips, 19 August 2022, 2892 [10–14].
- 552 Statement of Vincenzo Caltabiano, 13 July 2022, 4 [24].
- 553 Statement of Vincenzo Caltabiano, 13 July 2022, 4 [24].
- 554 Kelly Richards and Lauren Renshaw, *Bail and Remand for Young People in Australia: A National Research Project* (Report, Australian Institute of Criminology Research and Public Policy Series 125, 2013) 58.
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- 558 Statement of Hannah Phillips, 13 July 2022, 4 [22].
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- 561 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 32.
- 562 Save the Children, *New Launceston Office* (Web Page, 16 April 2019) <<https://www.savethechildren.org.au/media/media-releases/new-launceston-office>>; Save the Children, *Save the Children Opens First Devonport Office* (Web Page, 13 September 2018) <<https://www.savethechildren.org.au/media/media-releases/devonport-office-opening>>.
- 563 Tasmanian Aboriginal Legal Service, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (11 March 2022) 10.
- 564 Kelly Richards and Lauren Renshaw, *Bail and Remand for Young People in Australia: A National Research Project* (Report, Australian Institute of Criminology Research and Public Policy Series 125, 2013) 92.
- 565 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 32.
- 566 Kelly Richards and Lauren Renshaw, *Bail and Remand for Young People in Australia: A National Research Project* (Report, Australian Institute of Criminology Research and Public Policy Series 125, 2013) 92.
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- 568 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 32; Tasmania Legal Aid, *Children First: Children in the Child Safety and Youth Justice System* (Report, July 2021) 19.



- 569 *Youth Justice Act 1997* s 24B.
- 570 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 33–34.
- 571 Tasmanian Aboriginal Legal Service, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (11 March 2022) 10–11.
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- 573 *Bail Act 1977* (Vic) s 3B(1).
- 574 *Bail Act 1977* (Vic) s 3B(3).
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- 576 Sentencing Advisory Council Victoria, *Children Held on Remand in Victoria: A Report On Sentencing Outcomes* (Report, September 2020) ix. We note that, in January 2023, the Victorian Premier announced that the Victorian Government would introduce bail reforms in the first half of 2023: Adeshola Ore, 'Daniel Andrews Promises Victorian Bail Law Reform after Inquest into Veronica Nelson's Death', *The Guardian* (online, 31 January 2023) <<https://www.theguardian.com/australia-news/2023/jan/31/daniel-andrews-promises-victorian-bail-law-reform-after-inquest-into-veronica-nelsons-death>>.
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- 582 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 17.
- 583 Tasmanian Government, Department for Education, Children and Young People, *Assisted Bail Facilities* (undated) <<https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/Youth-Justice-Assisted-Bail-Facilities.pdf>>.
- 584 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 June 2023, 5.
- 585 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 6.
- 586 United Nations Committee on the Rights of the Child, *General Comment No. 24 (2019) on Children's Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 14 [86].
- 587 *United Nations Standard Minimum Rules for the Administration of Juvenile Justice ('The Beijing Rules')* GA Res 40/33, UN Doc A/RES/40/33 (adopted 29 November 1985) rule 13.1.
- 588 United Nations Committee on the Rights of the Child, *General Comment No. 24 (2019) on Children's Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 12 [73].
- 589 *Youth Justice Act 1997* ss 32, 37(1), 47(1).
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- 591 *Youth Justice Act 1997* s 47(1)(a).
- 592 *Youth Justice Act 1997* s 47(1)(b).
- 593 *Youth Justice Act 1997* ss 47(1)(c), 51.
- 594 *Youth Justice Act 1997* ss 47(1)(d), 54.
- 595 *Youth Justice Act 1997* ss 47(1)(e), 57.
- 596 *Youth Justice Act 1997* ss 47(1)(f), 65.
- 597 *Youth Justice Act 1997* ss 3, 6A, 47(1)(g), 69.

- 598 *Youth Justice Act 1997* ss 47(1)(h), 79, 81, 90.
- 599 *Youth Justice Act 1997* ss 3, 47(1)(i).
- 600 *Youth Justice Act 1997* ss 47(1)(j), 56A.
- 601 *Youth Justice Act 1997* s 37.
- 602 *Youth Justice Act 1997* ss 38–40.
- 603 *Youth Justice Act 1997* s 41.
- 604 *Youth Justice Act 1997* s 47(3A).
- 605 *Youth Justice Act 1997* s 47(4).
- 606 *Youth Justice Act 1997* s 48(1).
- 607 *Youth Justice Act 1997* s 5(1)(g).
- 608 *Youth Justice Act 1997* s 5(1)(i).
- 609 *Youth Justice Act 1997* s 5(1)(h).
- 610 *Youth Justice Act 1997* s 4(h).
- 611 Sentencing Advisory Council Tasmania, ‘Sentencing Young Offenders’ (Research Paper No. 6, October 2021).
- 612 Sentencing Advisory Council Tasmania, ‘Sentencing Young Offenders’ (Research Paper No. 6, October 2021) 81.
- 613 Sentencing Advisory Council Tasmania, ‘Sentencing Young Offenders’ (Research Paper No. 6, October 2021) 81.
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- 621 Statement of Anthony McGinness, 6 July 2022, 5 [20].
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- 625 Jesuit Social Services, *Ignatius Learning Centre* (Web Page, 2023) <<https://jss.org.au/programs/ignatius-learning-centre/>>.
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- 627 Jesuit Social Services, *Ignatius Learning Centre Enrolment Policy* (February 2021) 1 <<https://cdn.jss.org.au/wp-content/uploads/2022/12/15102155/ILC-Enrolment-Policy.pdf>>.
- 628 Jesuit Social Services, *Ignatius Learning Centre* (Web Page, 2023) <<https://jss.org.au/programs/ignatius-learning-centre/>>. We note that the Victorian Certificate of Applied Learning has been replaced by the new Victorian Pathways Certificate and the Victorian Certificate of Education – Vocational Major (refer to Section 6.6.3).

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- 630 Sentencing Advisory Council Victoria, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court* (Report, June 2019) 93; Sentencing Advisory Council Victoria, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 2: Children at the Intersection of Child Protection and Youth Justice across Victoria* (Report, April 2020) 2.
- 631 Tasmania Legal Aid, *Children First: Children in the Child Safety and Youth Justice System* (Report, July 2021) 4, 9.
- 632 Tasmania Legal Aid, *Children First: Children in the Child Safety and Youth Justice System* (Report, July 2021) 9.
- 633 Tasmania Legal Aid, *Children First: Children in the Child Safety and Youth Justice System* (Report, July 2021) 10.
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- 635 Sentencing Advisory Council Victoria, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 3: Sentencing Children Who Have Experienced Trauma* (Report, June 2020) xii.
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- 637 Sentencing Advisory Council Victoria, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 3: Sentencing Children Who Have Experienced Trauma* (Report, June 2020) xiii.
- 638 Sentencing Advisory Council Victoria, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 3: Sentencing Children Who Have Experienced Trauma* (Report, June 2020) xiii.
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- 643 Sentencing Advisory Council Tasmania, *'Sentencing Young Offenders'* (Research Paper No. 6, October 2021) 54.
- 644 Magistrates Court of Tasmania, *Youth Justice Court* (Web Page) <[https://www.magistratescourt.tas.gov.au/about\\_us/youth\\_justice\\_division](https://www.magistratescourt.tas.gov.au/about_us/youth_justice_division)>.
- 645 Sentencing Advisory Council Tasmania, *'Sentencing Young Offenders'* (Research Paper No. 6, October 2021) 54.
- 646 *Children, Young Persons and Their Families Act 1997* s 3 (definition of 'Court'); Magistrates Court of Tasmania, *Children's Court* (Web Page) <[https://www.magistratescourt.tas.gov.au/about\\_us/childrens\\_division](https://www.magistratescourt.tas.gov.au/about_us/childrens_division)>.
- 647 Statement of Robert White, 16 August 2022, 24 [108–109].
- 648 Commissioner for Children and Young People, *Procedural Fairness Response*, 15 June 2023, 4–7.
- 649 Commissioner for Children and Young People, *Procedural Fairness Response*, 15 June 2023, 6.
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- 653 Tasmania Legal Aid, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (undated) 6.
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- 655 Transcript of Vincenzo Caltabiano, 19 August 2022, 2902 [32–42], 2903 [22–24].

- 656 Commissioner for Children and Young People, Submission to Department of Communities, *Reforming Tasmania's Youth Justice System* (21 March 2022) 52.
- 657 Sentencing Advisory Council Tasmania, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 1.
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- 663 Statement of Mark Morrissey, 9 August 2022, 8 [54].
- 664 Statement of Robert White, 16 August 2022, 14 [57]; Transcript of James Ogloff, 13 September 2022, 3975 [36–40]; Transcript of Vincenzo Caltabiano, 19 August 2022, 2899 [31–36]; Transcript of Janise Mitchell, 18 August 2022, 2845 [4–17]. The Tasmanian Sentencing Advisory Council has identified similar factors as the characteristics of young offenders: Sentencing Advisory Council, 'Sentencing Young Offenders' (Research Paper No. 6, October 2021) 10–11.
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- 666 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 442–444.
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- 668 Sentencing Advisory Council, Victoria, *Reoffending by Children and Young People in Victoria* (Report, December 2016) 41; Statement of Hannah Phillips, 13 July 2022, 20 [102–103].
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- 671 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 433.
- 672 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 434–435.
- 673 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 435.
- 674 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 436–437.
- 675 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 438.
- 676 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 437.
- 677 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 439.
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- 679 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 440.

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- 682 Roger Jaensch, ‘Therapeutic Approach to Youth Justice Reforms’ (Media Release, 22 November 2022) <[https://www.premier.tas.gov.au/site\\_resources\\_2015/additional\\_releases/therapeutic-approach-to-youth-justice-reforms](https://www.premier.tas.gov.au/site_resources_2015/additional_releases/therapeutic-approach-to-youth-justice-reforms)>.
- 683 Department for Education, Children and Young People, *Keeping Children and Young People out of the Youth Justice System: Draft First Action Plan 2023–2025* (Draft Plan, January 2023) 17.
- 684 *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty*, GA Res 45/113, UN Doc A/RES/45/113 (4 April 1991) annex, 206 [17].
- 685 United Nations Committee on the Rights of the Child, *General Comment No 24 (2019) on Children’s Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 15 [95(b)].
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- 687 *Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory* (Report, November 2017) vol 2B, 444.
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- 695 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 15.
- 696 Statement of Dale Tolliday, 30 April 2022, 8 [31–33].
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- 1275 Commissioner for Children and Young People, *Procedural Fairness Response*, 12 July 2023, 3.
- 1276 Commissioner for Children and Young People, *Procedural Fairness Response*, 12 July 2023, 5.
- 1277 Letter from Timothy Bullard to Commission of Inquiry, 3 August 2023, 1–2.
- 1278 Letter from Timothy Bullard to Commission of Inquiry, 3 August 2023, 2.
- 1279 Transcript of Sarah Spencer, 18 August 2022, 2818 [27–39]. Refer, for example, to Luke Miller, 'Ashley Lockdowns Scrutinised over a Week Since Commencing', *The Examiner* (Launceston, 3 July 2022); Luke Miller, 'Ashley Lockdowns Resume', *The Examiner* (Launceston, 24 October 2022); Lucy MacDonald, 'Inside Tasmania's Troubled AYDC, where Kids Say They Get No Help', *ABC News* (5 December 2022).
- 1280 Transcript of Samuel Baker, 19 August 2022, 2914 [23–36]; Transcript of Leanne McLean, 24 August 2022, 3304 [40–46].
- 1281 Email from Investigation Officer, Ombudsman Tasmania to the Office of the Secretary of the Department of Communities, 15 November 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Michael Pervan to Investigation Officer, Ombudsman Tasmania, 29 November 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Investigation Officer, Ombudsman Tasmania to Michael Pervan, 8 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1282 Letter from Investigation Officer, Ombudsman Tasmania to Michael Pervan, 8 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1283 Transcript of Leanne McLean, 24 August 2022, 3303 [30–43].
- 1284 Statement of Vincenzo Caltabiano, 13 July 2022, 10–11 [65]; Statement of Hannah Phillips, 13 July 2022, 15 [74].
- 1285 Transcript of Lucas Digney, 24 August 2022, 3265 [3–14].



- 1286 Transcript of Mark Morrissey, 18 August 2022, 2786 [13–23]; refer also to Statement of Mark Morrissey, 9 August 2022, 10 [61–62].
- 1287 United Nations Committee against Torture, *Concluding Observations on the Sixth Periodic Report of Australia*, UN Doc C/AUS/CO/6 (5 December 2022, adopted on 22 and 23 November 2022) 11 [37(d)].
- 1288 United Nations Committee against Torture, *Concluding Observations on the Sixth Periodic Report of Australia*, UN Doc C/AUS/CO/6 (5 December 2022, adopted on 22 and 23 November 2022) 11 [37(d)].
- 1289 Commissioner for Children and Young People, *Procedural Fairness Response*, 12 July 2023, 3.
- 1290 Statement of Pamela Honan, 18 August 2022, 29 [42.2].
- 1291 Transcript of Michael Pervan, 26 August 2022, 3531 [10–17]; Transcript of Richard Connock, 24 August 2022, 3307 [20–34].
- 1292 Transcript of Michael Pervan, 26 August 2022, 3531 [21–29].
- 1293 Transcript of Michael Pervan, 26 August 2022, 3531 [39]–3532 [6].
- 1294 Statement of Stuart Watson, 16 August 2022, 11 [71(b)].
- 1295 *Youth Justice Act 1997* s 133(1).
- 1296 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1297 Refer, for example, to Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.
- 1298 *Youth Justice Act 1997* s 133(2)(a).
- 1299 *Youth Justice Act 1997* s 133(2)(b).
- 1300 *Youth Justice Act 1997* s 133(4).
- 1301 *Youth Justice Act 1997* s 133(5).
- 1302 *Youth Justice Act 1997* s 133(6).
- 1303 *Youth Justice Act 1997* s 132(a).
- 1304 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) III [Abbreviations], 43 [8.9].
- 1305 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 43 [8.9], [8.9.1].
- 1306 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 43 [8.9.2].
- 1307 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 43 [8.9].
- 1308 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 43 [8.9.4].
- 1309 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 43 [8.9.5].
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- 1311 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce. Additional Practice Manual documents for using isolation include the ‘Authorisation for Use of Isolation’ form, ‘Authorisation for Extension of Isolation’ form, ‘Observation Record’ and ‘Use of Isolation Register’.
- 1312 *Youth Justice Act 1997* s 133(1); Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1313 Children and Youth Services, ‘Procedure: Use of Isolation’, 1 July 2017, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1318 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1320 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1321 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1322 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1323 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1324 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1326 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1328 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 2.
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- 1333 Statement of Michael Pervan, 27 July 2022, 74 [255].
- 1334 Statement of Michael Pervan, 27 July 2022, 72 [242].
- 1335 Commissioner for Children and Young People, *Procedural Fairness Response*, 12 July 2023, 3.
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- 1338 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1339 Statement of Michael Pervan, 27 July 2022, 72 [246].
- 1340 Statement of Michael Pervan, 27 July 2022, 48 [94].

- 1341 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 7, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1342 Statement of Michael Pervan, 27 July 2022, 61 [177].
- 1343 *Youth Justice Act 1997* s 132(a).
- 1344 *Children, Youth and Families Act 2005* (Vic) s 487(a).
- 1345 *Children (Detention Centres) Act 1987* (NSW) ss 19, 22(1)(h), 22(3). The maximum penalty for this offence is 10 penalty units or imprisonment for a period not exceeding 12 months or both (s 22(3)).
- 1346 Department for Education, *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System* (Draft Report, 3 February 2023) 31.
- 1347 Statement of Michael Pervan, 27 July 2022, 72 [242].
- 1348 Statement of Michael Pervan, 6 June 2022, 52 [232].
- 1349 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 6.
- 1350 Isabel Bird, 'Locked Down at Ashley for up to 23 Hours "Every Day"', *The Examiner* (Launceston, 8 July 2023); Commissioner for Children and Young People, *ABC Radio – Lockdowns at AYDC for up to 23 Hours a Day* (Web Page, 6 July 2023) <<https://childcomm.tas.gov.au/abc-radio-lockdowns-at-aydc-for-up-to-23-hours-a-day/>>.
- 1351 Statement of Lucas Digney, 9 August 2022, 10 [30].
- 1352 *Youth Justice Act 1997* s 133(2)(b).
- 1353 Request for statement served on Michael Pervan, 25 May 2022, 9 [20], [21], 15 [54(d)], 16 [54(e)]; Request for statement served on Michael Pervan, 2 August 2022, 26 [78]; Request for statement served on Stuart Watson, 22 July 2022, 11 [53(d)], [60(a) and (b)]; Request for statement served on Pamela Honan, 25 July, 6 [13(a) and (b)], 10 [37(e)].
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- 1357 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 8.
- 1358 Transcript of Stuart Watson, 23 August 2022, 3154 [35–44].
- 1359 *Youth Justice Act 1997* ss 131(5), 132(b), 133(4).
- 1360 *Youth Justice Act 1997* s 132(c).
- 1361 *Youth Justice Act 1997* s 25J.
- 1362 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.1].
- 1363 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3].
- 1364 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.5].
- 1365 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.2].
- 1366 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.8], [8.3.9].

- 1367 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.11], [8.3.12].
- 1368 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.13].
- 1369 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1370 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1371 Custodial Youth Justice, 'Procedure: Use of Mechanical Restraints (Handcuffs)', 21 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1372 Children and Youth Services, 'Practice Advice: Use of Mechanical Restraints', 21 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1373 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1374 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1375 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1376 Children and Youth Services, 'Practice Advice: Use of Mechanical Restraints', 21 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Custodial Youth Justice, 'Procedure: Use of Mechanical Restraints (Handcuffs)', 21 October 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1377 Custodial Youth Justice, 'Procedure: Use of Mechanical Restraints (Handcuffs)', 21 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1378 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 2, produced by the Tasmanian Government in response to a Commission notice to produce. In addition, Ashley Youth Detention Centre staff are prohibited from deploying any form of chemical agent designed to cause temporary incapacitation or sensory irritation, such as oleoresin capsicum spray: Statement of Michael Pervan, 20 December 2022, Annexure 80 ('Use of Chemical Agents and Restraints', Procedure, Custodial Youth Justice, 21 October 2019) 1.
- 1379 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1380 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1383 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.
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- 1385 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1386 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1387 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1388 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

- 1389 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1390 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1391 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1392 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1393 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce. The *Report on Use of Physical Force* form dated 1 July 2017 requires reasons for the use of force and details of the circumstances around the use of force, injuries to the young person, whether handcuffs were applied, the staff member(s) involved and injuries to staff. An authorisation section requires sign-off by the 'Supervisor', 'Operations Manager' and 'Manager': Children and Youth Services, *Report on Use of Physical Force* (Form, 1 July 2017).
- 1394 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1395 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1396 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1397 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1398 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1399 Statement of Pamela Honan, 18 August 2022, 11 [9.1–9.2].
- 1400 Statement of Pamela Honan, 18 August 2022, 12 [12.1].
- 1401 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1402 Statement of Pamela Honan, 18 August 2022, 11 [8.2].
- 1403 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 6, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1404 Department for Education, Children and Young People, *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre until Its Intended Closure* (Report to the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, October 2022) 21.
- 1405 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 1.
- 1406 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 2.
- 1407 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 1.
- 1408 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 1.
- 1409 Department for Education, Children and Young People, *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre until Its Intended Closure* (Report to the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, October 2022) 6.
- 1410 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.
- 1411 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.
- 1412 *Youth Justice Act 1997* s 132(b)(ii), (iii).
- 1413 *Children (Detention Centres) Act 1987* (NSW) s 22(1)(a), (2), (3).



- 1414 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1415 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1416 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.
- 1417 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 217.
- 1418 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 33.
- 1419 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 17, Recommendation 15.9.
- 1420 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 17, Recommendation 15.9.
- 1421 Transcript of 'Simon', 18 August 2022, 2758 [27–31], 2759 [15–18]; Transcript of 'Max', 23 August 2022, 3118 [5–13], 3122 [42–43]; Transcript of 'Fred', 25 August 2022, 3344 [15–42].
- 1422 Transcript of 'Fred', 25 August 2022, 3344 [15–21].
- 1423 Transcript of 'Warren', 18 August 2022, 2769 [6–15].
- 1424 Transcript of 'Max', 23 August 2022, 3118 [8–13].
- 1425 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 73.
- 1426 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 69.
- 1427 Statement of Angela Sdrinis, 5 May 2022, 68.
- 1428 Statement of Angela Sdrinis, 5 May 2022, 68.
- 1429 Statement of Angela Sdrinis, 5 May 2022, 68.
- 1430 Transcript of Mark Morrissey, 18 August 2022, 2775 [39–46].
- 1431 Statement of Mark Morrissey, 9 August 2022, 14 [87–88].
- 1432 Transcript of Mark Morrissey, 18 August 2022, 2774 [38–44]; Statement of Mark Morrissey, 9 August 2022, 14 [87]–15 [88].
- 1433 Statement of Mark Morrissey, 9 August 2022, 15 [88–89].
- 1434 Ashley Youth Detention Centre, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022).
- 1435 *Youth Justice Act 1997* s 129(1)(d).
- 1436 *Youth Justice Act 1997* s 138(1).
- 1437 *Youth Justice Act 1997* s 138(2).
- 1438 Notice to produce served on the State of Tasmania, 9 March 2022, 5–6 [12].
- 1439 Statement of Michael Pervan, 7 June 2022, Annexures 27–29 ('Responding to Feedback, Concerns and Complaints', Procedure, Custodial Youth Justice Services, undated; 'Feedback and Complaints', Practice Advice, Custodial Youth Justice Services, undated; 'Make a Complaint', Form, undated).
- 1440 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022); Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022).
- 1441 Ashley Youth Detention Centre, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022); Ashley Youth Detention Centre, *Help Form* (Form, 13 September 2022).
- 1442 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <<https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>>.
- 1443 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <<https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>>.

- 1444 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <<https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>>.
- 1445 Ashley Youth Detention Centre, 'Information for Young People and Families', undated, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1446 Ashley Youth Detention Centre, 'Information for Young People and Families', undated, 15–17, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1447 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 2.
- 1448 Department for Education, Children and Young People, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022) 1.
- 1449 Ashley Youth Detention Centre, *Help Form* (Form, 13 September 2022) 1–2.
- 1450 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 2.
- 1451 Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022) 1.
- 1452 Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022) 3.
- 1453 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.
- 1454 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 3.
- 1455 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1456 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1457 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.
- 1458 Statement of Michael Pervan, 23 August 2022, 54 [221].
- 1459 Statement of Pamela Honan, 18 August 2022, 17 [16–17]. The list of delegations under sections 137 and 138 of the *Youth Justice Act 1997* states that responsibility for complaints sits with Children and Youth Services: at 6–7 [3].
- 1460 Statement of Michael Pervan, 7 June 2022, 20 [128], 21 [133–136].
- 1461 Statement of Michael Pervan, 7 June 2022, 21 [136].
- 1462 Statement of Michael Pervan, 7 June 2022, 21–22 [137].
- 1463 Statement of Michael Pervan, 7 June 2022, 20 [128].
- 1464 Statement of Jacqueline Allen, 15 August 2022, 43 [247].
- 1465 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].
- 1466 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].
- 1467 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].
- 1468 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].
- 1469 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 2–3 [2].
- 1470 Statement of Jacqueline Allen, 15 August 2022, 32 [180].
- 1471 Statement of Jacqueline Allen, 15 August 2022, 32 [175].
- 1472 Statement of Jacqueline Allen, 15 August 2022, 37 [201].
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