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 1: Summary, recommendations and findings

August 2023

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

Volume 1
Summary, recommendations and findings

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August 2023

Volume 1: Summary, recommendations and findings
978-0-6457694-1-8
Published August 2023

ISBN:

Volume 1 978-0-6457694-1-8

Volume 2 978-0-6457694-2-5

Volume 3 978-0-6457694-3-2

Volume 4 978-0-6457694-4-9

Volume 5 (Book 1) 978-0-6457694-5-6

Volume 5 (Book 2) 978-0-6457694-5-6

Volume 5 (Book 3) 978-0-6457694-5-6

Volume 6 (Book 1) 978-0-6457694-6-3

Volume 6 (Book 2) 978-0-6457694-6-3

Volume 7 978-0-6457694-7-0

Volume 8 978-0-6457694-8-7

Suggested citation:
Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse (Report, August 2023).

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Acknowledgment of Aboriginal land

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

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse 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.

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

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

Your Excellency

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

Yours sincerely

The Hon. Marcia Neave AO President and Commissioner	**Professor Leah Bromfield** Commissioner	**The Hon. Robert Benjamin AM SC** Commissioner

31/08/2023

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Contents

VOLUME 1

Summary, recommendations and findings

Preface 1

Executive summary 3

1 Introduction 3

2 Why this Commission of Inquiry was necessary 4

3 Overall conclusions 8

4 Key reforms for safer institutions for children and young people 9

4.1 Creating a new, strengthened regulator and advocate for children and young people's rights and safety 9

4.2 Introducing a more coordinated and statewide response to child sexual abuse and harmful sexual behaviours 11

4.3 Increasing participation of children and young people, victim-survivors and service providers in policy design and delivery 13

4.4 Introducing stronger mechanisms for institutions to protect children in institutions from adults who pose a risk to them 14

4.5 Showing greater care, compassion and investment in protecting and healing marginalised children 16

4.6 Ensuring staff and volunteers working with children have the knowledge and skills they need 19

4.7 Valuing and strengthening the skills and expertise of those working in the child safety and youth justice systems 20

4.8 Monitoring reform 21

5 How we approached our task 22

5.1 Challenges we faced 25

6 What we heard 27

6.1 Tasmania's strengths and potential for reform 27

6.2 Encouraging reforms 28

6.3 Problems we identified in our Inquiry 31

7 The structure of our report 47

7.1 Volume 2—Establishment and context 48

7.2 Volume 3—Children in schools 50

7.3 Volume 4—Children in out of home care 53

7.4 Volume 5—Children in youth detention 58

7.5 Volume 6—Children in health services 64

7.6 Volume 7—The justice system and victim-survivors 69

7.7 Volume 8—Oversight, coordination and therapeutic support 73

Recommendations 79

Findings 196

Glossary 204

VOLUME 2
Establishment and context
1 Establishment, scope and conduct 1
2 The Tasmanian, national and international contexts 56
3 Child sexual abuse in institutions 103

VOLUME 3
Children in schools
Introduction to Volume 3 1
4 Background and context: Children in schools 5
5 Case studies: Children in schools 25
6 The way forward: Children in schools 100

VOLUME 4
Children in out of home care
Introduction to Volume 4 1
7 Background and context: Children in out of home care 5
8 Case examples and our approach: Children in out of home care 40
9 The way forward: Children in out of home care 85

VOLUME 5
Children in youth detention (Book 1)
Introduction to Volume 5 1
10 Background and context: Children in youth detention 5
11 Case studies: Children in youth detention 92

VOLUME 5
Children in youth detention (Book 2)
11 Case studies: Children in youth detention (continued) 1

VOLUME 5
Children in youth detention (Book 3)
12 The way forward: Children in youth detention 1

VOLUME 6

Children in health services (Book 1)

	Introduction to Volume 6	1
13	Background and context: Children in health services	7
14	Case studies: Children in health services	34

VOLUME 6

Children in health services (Book 2)

15	The way forward: Children in health services	1

VOLUME 7

The justice system and victim-survivors

	Introduction to Volume 7	1
16	Criminal justice responses	3
17	Redress, civil litigation and support	134

VOLUME 8

Oversight, coordination and therapeutic support

	Introduction to Volume 8	1
18	Overseeing child safe organisations	4
19	A coordinated approach	95
20	State Service disciplinary processes	152
21	Therapeutic services	230
22	Monitoring reforms	296
23	Afterword	316
	Appendices	329

Preface

Who was looking after me?

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

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

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

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

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

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

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

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

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

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

We must not look away.

Executive summary

1 Introduction

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

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

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

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

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

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

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

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

2 Why this Commission of Inquiry was necessary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Overall conclusions

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

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

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

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

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

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

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

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

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

4 Key reforms for safer institutions for children and young people

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our Inquiry demonstrates that system reform is urgently needed. We acknowledge that transforming a youth detention system that has resisted 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. The Tasmanian Government has acknowledged the need to move to an evidence-based, therapeutic model of care for children and young people in the youth justice system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.8 Monitoring reform

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

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

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

5 How we approached our task

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1 Challenges we faced

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

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

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

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

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

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

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

6 What we heard

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

6.1 Tasmania's strengths and potential for reform

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

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

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

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

6.2 Encouraging reforms

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

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

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

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

6.2.1 Child and Youth Safe Organisations Act

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

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

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

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

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

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

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

6.2.2 Decision to close Ashley Youth Detention Centre

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

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

6.2.3 Other welcome reforms

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

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

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

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

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

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

6.3 Problems we identified in our Inquiry

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

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

6.3.1 Poor understanding of child sexual abuse

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

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

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

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

Recommendations to address this issue include:

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

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

Harmful sexual behaviours need to be better understood and addressed.

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

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

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

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

Recommendations to address this issue include:

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

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

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

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

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

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

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

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

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

Recommendations to address this issue include:

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

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

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

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

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

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

Recommendations to address this issue include:

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

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

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

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

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

Recommendations to address underperforming institutions include:

- resourcing non-government out of home care providers appropriately (Recommendation 9.3) and building a quality out of home care system, including: outsourcing care to non-government providers; strengthening leadership, governance, strategic planning, outcomes and performance monitoring; supporting Aboriginal self-determination and implementing the Aboriginal and Torres Strait Islander Child Placement Principle; supporting quality care and carers; and meeting all children's needs, including by having specific measures to address harmful sexual behaviours and child sexual exploitation (Chapter 9)

- closing Ashley Youth Detention Centre (Recommendation 12.1) and preventing children entering youth detention, creating a child-focused youth detention system (Recommendations 12.16–12.26), addressing harmful sexual behaviours in youth detention (Recommendation 12.30), and protecting against the inappropriate or unlawful use of searches, isolation and use of force (Recommendations 12.31–12.33)

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

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

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

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

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

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

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

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

Recommendations to address this issue include ensuring:

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

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

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

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

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

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

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

Recommendations to address this issue include:

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

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

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

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

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

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

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

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

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

Recommendations to address this include:

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

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

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

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

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

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

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

Recommendations to address this include:

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

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

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

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

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

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

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

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

Recommendations to address this include:

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

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

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

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

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

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

Recommendations to address this include:

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

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

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

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

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

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

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

Recommendations to address this include:

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

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

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

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

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

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

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

Recommendations to address this include:

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

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

7 The structure of our report

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

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

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

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

7.1 Volume 2—Establishment and context

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.2 Volume 3—Children in schools

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.3 Volume 4—Children in out of home care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.4 Volume 5—Children in youth detention

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

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

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

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

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

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

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

In **Chapter 11 Case studies: Children in youth detention**, we share seven case studies looking at different aspects of Ashley Youth Detention Centre. In Case study 1, we describe the nature and extent of abuse at the Centre, including the evidence we received from a number of 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, are striking and include:

- sexual, physical and psychological abuse of detainees by staff
- harmful sexual behaviours between detainees, sometimes with the knowledge of Centre staff
- staff using strip searching 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 the accounts we read in claims under the Abuse in State Care Program and the National Redress Scheme. Despite being 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) in the accounts of where and how abuses occurred, the people they alleged were responsible and the patterns and consistency in specific 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 sexual behaviours, of some detainees to control or frighten other detainees. We make findings in this case study about the failures in responding appropriately to the risks of harmful sexual behaviours, which are listed later in this volume 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:

- using 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 practices, such as isolation, are still occurring
- the excessive use of force has been a long standing 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 increase. 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 have examples of 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).[53] We make findings about the State's, the Department's 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 because of 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.

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

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

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

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

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

We have made the significant recommendation that the Department initiates a change management process that requires all 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.

This recommendation, alongside others, may well add to pressure on staffing levels in the short term. The Tasmanian 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.

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

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. It follows that strategies to divert children and young people from the youth justice system and from detention should be prioritised. Our recommendations include a strong focus on increasing opportunities for bail, reducing the number of children who are remanded to custody and ensuring detention is an option of last resort.

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

We consider that an effective youth detention system is one that is child-focused—that 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. These features are necessary to reduce reoffending and promote community safety.

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

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

It was apparent from evidence we heard 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. Although legislative and procedural improvements have recently been implemented for searches of children and young people in detention, we recommend that the Government introduces body scanner technology in youth detention to reduce the need for more intrusive searches and strengthen safeguards in custodial procedures for searching children in detention.

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

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

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

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

Independent external oversight is a vital part of safeguarding children in detention facilities, 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 in detention need access to regular visits from the staff of an independent oversight body who have the skills and experience to build rapport and trust with detainees and to advocate on their behalf. To this end, we recommend that the Government establishes an independent community visitor program for children in detention, to be administered by the new Commission for Children and Young People and led by the new Child Advocate.

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

7.5 Volume 6—Children in health services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.6 Volume 7—The justice system and victim-survivors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.7 Volume 8—Oversight, coordination and therapeutic support

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

Child sexual abuse prevention education in schools

Recommendation 6.1

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

b. define the roles and responsibilities of key participants

c. include criteria for evaluating the curriculum.

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

Office of Safeguarding

Recommendation 6.2

1. The Office of Safeguarding within the Department for Education, Children and Young People should focus primarily on safeguarding children in the education context, with a particular focus on prevention, risk identification, policy development and related workforce development.

2. The Office of Safeguarding should not be involved in critical incident management beyond learning from systemic reviews and trend data.

Policies, procedures and guidance in education

Recommendation 6.3

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

2. The Department should establish a regular review process for its child safeguarding policies.

Recommendation 6.4

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 schools

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

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

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

Professional development

Recommendation 6.5

1. The Department for Education, Children and Young People should adopt and implement a training certification program that is mandatory for all education staff and volunteers. This training should be structured to provide basic and advanced levels of training for different role holders and targeted most directly at staff and volunteers operating in higher-risk settings.

2. Training should cover:

   a. key safeguarding policies of the Department, including appropriate standards of behaviour between adults and students and what to do if child sexual abuse or harmful sexual behaviours are witnessed or disclosed

   b. relevant legal obligations, including requirements for reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, and the Teachers Registration Board.

3. Training should be refreshed periodically and delivered at a time and in a format that will maximise engagement. It should be centrally recorded to monitor participation.

4. The Department should work with the Teachers Registration Board to establish the minimum training requirements for teachers (Recommendation 6.15).

Responding to and investigating complaints and concerns

Recommendation 6.6

1. The Tasmanian Government should establish a Child-Related Incident Management Directorate to respond to:

    a. allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in schools, Child Safety Services, out of home care and youth justice

    b. other forms of staff-perpetrated abuse in schools, Child Safety Services, out of home care and youth justice, including other serious care concerns and allegations of excessive use of force, inappropriate isolation or inappropriate searches of children and young people in detention.

2. The directorate should comprise three units tasked as follows:

    a. **Incident Report Management Unit.** This unit should be responsible for case management—that is, assisting child-facing services within the Department for Education, Children and Young People with the management of incidents or allegations of child sexual abuse and related conduct, including being the point of contact for these services.

    b. **Investigations Unit.** This unit should undertake preliminary assessments and investigations. It should comprise appropriately trained and skilled investigators or use external investigators with the requisite qualifications and training.

    c. **Adjudication Unit.** This unit should examine the investigation reports prepared by investigators and make recommendations to the Head of Agency about what disciplinary decisions are available and the appropriate response. The unit should be staffed by personnel with relevant experience, including a background in law.

3. The directorate should appoint staff with knowledge of schools, Child Safety Services, out of home care, and youth justice.

4. Within 12 months of appointment, all staff in the Investigations Unit should:

    a. undertake specialist training in interviewing vulnerable witnesses

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

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

Recommendation 6.7

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

Recommendation 6.8

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

Harmful sexual behaviours

Recommendation 6.9

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

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

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

Teacher registration

Recommendation 6.10

The Tasmanian Government should introduce legislation to:

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

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

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

Recommendation 6.11

The Tasmanian Government should:

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

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

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

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

Recommendation 6.12

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

Recommendation 6.13

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

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

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

Recommendation 6.14

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

Recommendation 6.15

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

Recommendation 6.16

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

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

Funding

Recommendation 9.1

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

The role of the Department

Recommendation 9.2

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

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

Contract management and auditing

Recommendation 9.3

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

Expert and active leadership

Recommendation 9.4

1. The Tasmanian Government should fund and restructure the Department for Education, Children and Young People to ensure (in addition to the current roles of Deputy Secretary for Keeping Children Safe, and the Executive Director for Youth Justice):
   a. there is separate executive-level responsibility for out of home care services
   b. there is separate executive-level responsibility for the combined areas of Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line and family support services
   c. the classification level of these executive roles reflects the level of risk and responsibility carried by the positions
   d. the holders of these executive roles have knowledge and understanding in the area of child protection or out of home care and experience in providing strategic direction and leadership
   e. executive responsibility for child safeguarding in the education context is not combined with responsibility for child safeguarding in the children and family services context
   f. the role of Executive Director for Aboriginal Children and Young People is established and supported by an Office of Aboriginal Policy and Practice (Recommendation 9.7)
   g. the role of the Chief Practitioner is established and supported by an Office of the Chief Practitioner (Recommendation 9.17)
   h. expertise among members of the Department's executive is evenly balanced across the areas of education, Child Safety Services, out of home care, and youth justice
   i. the relevant specialist for out of home care and youth justice in the executive leads policy and practice development for those areas
   j. relevant centralised functions within the Department, such as human resources, procurement, and staff learning and development, address the distinct needs of schools, Child Safety Services, out of home care and youth detention.

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

Governance

Recommendation 9.5

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

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

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

Recommendation 9.6

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

Recommendation 9.7

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

a. report directly to the Secretary

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

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

d. facilitate departmental engagement and build partnerships with Aboriginal communities

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

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

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

h. increase recruitment of Aboriginal staff in the Department

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

Strategic planning for out of home care

Recommendation 9.8

1. The Department for Education, Children and Young People should develop a strategic plan for the out of home care system. The plan should include:

   a. a vision for future models of out of home care in Tasmania

   b. the transition plan and commissioning strategy for outsourcing the provision of out of home care to the non-government sector (Recommendation 9.2)

   c. the empowerment and participation strategy for children and young people in out of home care (Recommendation 9.6)

   d. implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15)

   e. a commitment to trauma-informed, therapeutic models of care (Recommendation 9.18)

   f. a commitment to the National Standards for Out-of-Home Care and the Child and Youth Safe Standards

   g. a workforce capacity building strategy (Recommendation 9.10)

   h. developing a carer recruitment, support and retention strategy, in consultation with the non-government sector

   i. a process for ongoing carer accreditation, registration and monitoring (Recommendation 9.20)

   j. establishing the outcomes and performance reporting framework (Recommendation 9.9)

   k. building quality assurance and improvement into all activities

   l. an updated framework of policies for the safety and wellbeing of children in care, including updating key policies relating to

      i. complaints handling

      ii. harmful sexual behaviours

      iii. mandatory education for staff in child sexual abuse

      iv. care concern and critical incident reporting and management

      v. child sexual exploitation

vi. how decisions can be appealed and reviewed

vii. professional conduct

viii. implementing the Child and Youth Safe Standards.

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

Outcomes and performance reporting

Recommendation 9.9

The Department for Education, Children and Young People should:

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

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

c. routinely report against the framework.

Workforce strategy

Recommendation 9.10

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

a. an increase in staff numbers and retention

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

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

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

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

Recommendation 9.11

1. The Department for Education, Children and Young People should establish mandatory core knowledge requirements for Child Safety Officers, which include an understanding of:

    a. child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation

    b. the effects of trauma, trauma-informed care and therapeutic responses to trauma

    c. ethical and professional conduct.

2. The Department should ensure Child Safety Officers attain this knowledge during their induction period.

3. The Department should provide regular refresher training and continuous professional development opportunities to enable Child Safety Officers to continue to advance their knowledge and skills (advanced professional development).

4. In its role of overseeing the out of home care system, the Department should:

    a. determine the core knowledge and skills required for staff in non-government organisations providing carer assessment and support, and for residential, foster and kinship carers

    b. ensure non-government out of home care staff and carers have access to professional development in core knowledge and skills, recognising existing high-quality training available in Tasmania and developing or funding new training where required.

Recommendation 9.12

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

Recommendation 9.13

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

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

Keeping Aboriginal children safe

Recommendation 9.14

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

Recommendation 9.15

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

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

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

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

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

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

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

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

e. partnering with Aboriginal communities to

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

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

iii. invest in recognised Aboriginal organisations' capacity to ensure they 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, including involvement in cultural support planning, and to manage any transfer of decision-making authority for Aboriginal children

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

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

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

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

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

Supporting quality care

Recommendation 9.16

1. The Department for Education, Children and Young People should:

   a. ensure all children in care, including those on guardianship orders until age 18, have a case manager

   b. set a maximum case load for Child Safety Officers.

2. The Department should report quarterly to the Quality and Risk Committee on the:

   a. number of children without an individual case manager

   b. average case load for Child Safety Officers

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

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

e. average frequency of care team meetings

f. percentage of children with a current care plan.

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

Recommendation 9.17

1. The Department for Education, Children and Young People should appoint a Chief Practitioner to lead clinical practice and quality assurance across Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line, and out of home care.

2. The Chief Practitioner should lead an Office of the Chief Practitioner, manage a team of clinical practice experts across Child Safety Services and report to the Secretary.

3. The Chief Practitioner should be responsible for:

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

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

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

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

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

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

Recommendation 9.18

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

Recommendation 9.19

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

Ensuring quality carers

Recommendation 9.20

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

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

Recommendation 9.21

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

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

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

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

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

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

Meeting children's needs

Recommendation 9.22

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

Recommendation 9.23

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

Recommendation 9.24

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

Recommendation 9.25

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

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

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

Recommendation 9.26

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

a. each child is involved in developing their care plan

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

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

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

Children on out of home care orders involved in youth justice

Recommendation 9.27

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

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

   i. support the child in court

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

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

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

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

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

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

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

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

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

Harmful sexual behaviour

Recommendation 9.28

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

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

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

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

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

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

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

Child sexual exploitation

Recommendation 9.29

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

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

Recommendation 9.30

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

Responding to complaints and concerns about child sexual abuse

Recommendation 9.31

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

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

Recommendation 9.32

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

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

Independent advocacy and oversight

Recommendation 9.33

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

Recommendation 9.34

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

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

Recommendation 9.35

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

Recommendation 9.36

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

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

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

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

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

Recommendation 9.37

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

Recommendation 9.38

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

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

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

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

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

e. administering the independent community visitor scheme

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

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

Chapter 12 – The way forward: Children in youth detention

Addressing the legacy of abuse

Recommendation 12.1

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

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.

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.

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.

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.

Cultural change

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.

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.

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.

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.

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.

Reducing the number of children in youth detention

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.

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.

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.

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.

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.

Creating a child-focused youth detention system

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Aboriginal children in youth detention

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.

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.

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.

Harmful sexual behaviours in youth detention

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.

Searches, isolation and use of force

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.

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.

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.

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.

Responding to concerns, complaints and critical incidents in detention

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.

Independent oversight of youth detention

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.

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).

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.

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.

Chapter 15 – The way forward: Children in health services

A policy framework and implementation plan

Recommendation 15.1

The Department of Health should develop and communicate a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. The policy and implementation plan should:

a. set out the purpose and need for the reforms

b. set out the role, responsibilities and interactions of bodies the Department has set up as part of the reforms

c. explain how reforms, including departmental reforms and those recommended by the Child Safe Governance Review, Community Recovery Initiative and this Commission of Inquiry, will work together to respond to child sexual abuse in health services

d. outline how the reforms are being prioritised for implementation and who is responsible for their implementation

e. set out the expected timeframes for implementation

f. be published on the Department's website.

Implementing the National Principles for Child Safe Organisations

Recommendation 15.2

1. The Tasmanian Government and Department of Health should continue to implement the National Principles for Child Safe Organisations across all health services.
2. The Tasmanian Government should advocate at a national level for compliance with the National Principles for Child Safe Organisations to be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme.

Protecting children through a safety culture

Recommendation 15.3

The Department of Health should ensure its cultural improvement program embeds a safety culture in health services by:

a. requiring clear organisational values be observed across all levels of health services, including in relation to staff conduct

b. establishing strong governance arrangements to address staff practices that place children at risk of abuse, and complementing established patient safety governance structures

c. ensuring all levels of management demonstrate a commitment to a safety culture, including by addressing poor staff conduct

d. clarifying roles and responsibilities among staff when there is a suspicion that child sexual abuse has occurred or that safety policies are not observed

e. ensuring there are processes that hold senior managers and executives accountable to respond appropriately to the conduct of their staff, including through performance agreements and role descriptions

f. establishing measures of a strong organisational culture that indicate an organisation

i. welcomes concerns about staff and sees them as an opportunity to improve safety for staff and patients

ii. empowers staff to feel safe and supported to raise concerns about colleagues with their leaders and gives them confidence in the ability of leaders to respond to concerns and take disciplinary actions (including termination) where appropriate

iii. ensures staff are clear about the process for raising concerns, how these concerns will be addressed and what feedback they can expect to receive

g. providing progress reports to the Child Sexual Abuse Reform Implementation Monitor to demonstrate how these principles have been translated into policy and practice (Recommendation 22.1).

Recommendation 15.4

1. The Department of Health should consider integrating features of the St Vincent's Health Australia's Ethos Program into its cultural improvement program.
2. The Department of Health should ensure, in adopting its cultural improvement program, professional boundary breaches by staff towards a child are always formally reported, responded to and recorded in centralised records for future reference.

Embedding child safety as a priority for leadership

Recommendation 15.5

The Department of Health should make health leadership accountable for embedding child safety as a priority, including by:

a. ensuring that all relevant health leaders have an obligation to act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) in their role descriptions and performance agreements, with compliance with this obligation to be reviewed annually

b. ensuring that the role descriptions and performance agreements of all staff providing services to children require them to protect child safety, with compliance with this obligation to be considered as part of annual performance reviews.

Recommendation 15.6

The Department of Health, to support health services become child safe organisations, should ensure:

a. child safety, including safety from abuse in health services, is overseen by the governance and leadership structures established through the cultural improvement program

b. child safety is built into the safety and quality systems of health services

c. staff responsible for providing care to children have the knowledge and skills to respond to child safety concerns in line with the expectations of a child safe organisation and relevant health service policies, including being equipped to identify and respond to indicators of child sexual abuse

d. staff act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) when performing their work, including in discussions between health practitioners, health workers and children about care planning and treatment.

Empowering children, families and carers

Recommendation 15.7

1. The Department of Health should establish a health services young people's advisory group. The advisory group should:

   a. have a clear purpose and objectives

   b. be guided by clear terms of reference developed in consultation with children and young people

   c. comprise young people with significant lived experience of health services, including young people of different ages, from diverse backgrounds and with different care needs

   d. enable young people to contribute to decision making in a safe and meaningful way about issues that affect them

   e. allow young people to have a say in departmental strategies, policies, procedures and protocols that affect them

   f. be adequately funded and resourced.

2. Summaries of the health services young people's advisory group meetings should be prepared and distributed to all senior executive teams in the Department.
3. The Department should report on the activities of the health services young people's advisory group and on other engagement with children and young people through its annual report.
4. The Department should undertake other age-appropriate engagement with children to ensure as many children and young people as possible can take part in shaping health services.

Recommendation 15.8

1. The Department of Health should ensure consistent information is provided to patients, including suitable age-appropriate resources for children and young people and their families and carers, across its health services. These resources should include information on:
    a. requirements and expectations of a child safe organisation
    b. patient rights when receiving health care, including the rights of children and young people
    c. expected standards of behaviour for health service staff
    d. processes for raising concerns and making complaints internally and externally
    e. roles of health regulatory bodies in receiving complaints.
2. This information should be provided in formats that meet community needs, especially for those with less capacity to comprehend complex written text.

Recommendation 15.9

The Department of Health should require its health services to undertake regular and ongoing monitoring of children and young people's sense of safety in health services to inform continuous improvements to child safety, including in the safety of the physical environment.

Recommendation 15.10

The Department of Health should work with relevant stakeholders to consider the needs and backgrounds of children and young people using health services, including Aboriginal children, children from culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+. The Department should consult with Aboriginal communities on how it can provide culturally safe spaces for Aboriginal children across its health services.

Policies, procedures and protocols on child safety

Recommendation 15.11

1. The Department of Health should review and consolidate its policies, procedures and protocols. This review should prioritise identifying gaps in relation to safeguarding children and should inform the development and implementation of consistent statewide policies, procedures and protocols on child safety.
2. The Department's safeguarding policies should include implementing the National Principles for Child Safe Organisations and other recommended policy changes (namely, policies on reporting obligations, professional conduct and providing a chaperone (Recommendations 15.12, 15.13 and 15.14)).
3. The Department should undertake regular scheduled reviews of its policies, procedures and protocols for child safety to ensure they continue to reflect best practice and organisational changes.
4. The Department should publish its policies, procedures and protocols for child safety on its website to promote transparency and ensure accessibility to staff, patients and their families.

Recommendation 15.12

1. The Department of Health should ensure there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, and that these are effectively communicated to staff. These policies must not require that reporting be formally authorised.
2. The Department's review of the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* and associated documents should include:

a. a description of external reporting requirements in relation to child safety, including voluntary reporting pathways, and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

b. guidance on when it is appropriate to acquit mandatory reporting obligations by reporting concerns to a superior (for example, to avoid multiple notifications). This should make clear that a person is always entitled to make a notification to an external agency if they wish to do so

c. a list of internal contacts for staff who have questions about child safety concerns and their reporting obligations.

Recommendation 15.13

1. The Department of Health, 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 health services

   b. the professional conduct policy for health services, in addition to the matters set out in Recommendation 20.2

      i. specifies expectations outlined in other relevant Department of Health policies and procedures

      ii. refers to other professional obligations of registered health practitioners, including those developed by the Australian Health Practitioner Regulation Agency and the National Boards

      iii. reflects the specific risks that arise in health services, particularly the sometimes intimate and invasive nature of health services, and the significant trust and power afforded by patients and the broader community to those providing health services

   c. the professional conduct policy for health services 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 for health services.

2. The professional conduct policy for health services should be reinforced through professional development requirements (Recommendation 15.15).

Recommendation 15.14

The Department of Health's chaperone (or Accompanying Person/Observer) policy should be updated to require the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.

Professional development for health service staff

Recommendation 15.15

1. The Department of Health should identify minimum requirements for professional development on child safety for different levels of staff, including staff, volunteers and contractors, as well as leadership. Professional development should cover, at a minimum:
   a. understanding child sexual abuse (including grooming and boundary breaches)
   b. the requirements and expectations of a child safe organisation
   c. mandatory and voluntary reporting obligations, including the role and function of Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
   d. relevant child safeguarding policies and procedures.
2. The Department should have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.
3. The Department should develop outcomes-based measures of the effectiveness of child safety professional development initiatives for all categories of staff, volunteers, and contractors, including management, leadership, human resources, and professional and non-professional staff.
4. These outcomes-based measures should be reviewed annually and the results used to inform further professional development initiatives and leadership selection.

Improving responses to child sexual abuse

Recommendation 15.16

1. The Department of Health should have a specific policy on responding to complaints and concerns about staff conduct. The policy should establish a complaints escalation, management and investigation process that is informed by the following principles:

   a. Complaints processes should be well-understood, trusted and accessible to staff, patients and others.

   b. Complaints processes should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety.

   c. There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.

   d. Complaints about child safety should be recorded comprehensively and stored securely in incident management (such as the Safety Reporting and Learning System) and human resources systems.

   e. Complaints about unprofessional conduct and boundary breaches with child patients should be recognised as indicating a patient safety issue and treated as serious.

   f. Complaints data should support decision making and inform system improvements.

   g. There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes (Recommendation 15.18).

2. The policy should include a diagram showing the complaints escalation, management and investigation pathways for child safety concerns and associated governance and review arrangements. It should also outline the roles and responsibilities of the various bodies involved in responding to child safety concerns.

3. This policy and diagram should be available to health service users and the public.

Recommendation 15.17

1. The Department of Health should establish a separate Health Services Child-Related Incident Management Directorate or partner with the Child-Related Incident Management Directorate (Recommendation 6.6) to respond to allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in health services.
2. If the Department partners with the Child-Related Incident Management Directorate, it should ensure the directorate has access to specialised advice to inform investigations against health services staff, particularly where allegations have arisen in the context of provision of health care.
3. If the Department establishes a new Health Services Child-Related Incident Management Directorate, it should mirror the functions and manner of operation reflected in the Child-Related Incident Management Directorate, including having three distinct roles and skill sets covering incident response management, investigations, and misconduct and disciplinary advice.

Recommendation 15.18

The Department of Health should ensure open disclosure processes for patients who experience child sexual abuse in health services and their families and carers that:

a. create a safe, trauma-informed pathway for victim-survivors, or others affected by an event, to receive clear and personalised information in response to their questions or concerns

b. facilitate appropriate notifications including to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

c. make appropriate supports available to affected people, including victim-survivors, their immediate family and carers, where abuse is connected to the Department's health services, including warm referrals, with the person's consent, to trained and experienced child sexual abuse counsellors.

Recommendation 15.19

The Department of Health should develop and implement a critical incident response plan for human-caused traumatic events where numerous staff and patients are affected, including serious child-related incidents. The response plan should:

a. identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements
b. identify the steps to responding to a human-caused traumatic event (including incidents relating to child safety)
c. provide for external assistance from experts with training and expertise in crisis management
d. be based on best practice responses to traumatic events
e. provide for early communication of information about the event
f. provide psychological first aid to affected people
g. provide extra support from skilled psychologists on an 'as needed' basis to affected people
h. provide for information about other support services that can assist affected people
i. facilitate communication and support among affected people as a means of social support
j. provide for critical incident debriefing run by a neutral and trained expert where appropriate
k. provide for a review of the Department's response to the critical incident
l. provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident
m. provide for any lessons from a review or an evaluation of the Department's response to the critical incident, to be shared with the Secretaries Board to further inform responses to critical incidents across the whole of government.

Restoring trust

Recommendation 15.20

1. The Department of Health, Launceston General Hospital and Tasmania Police should make clear that they will continue to assist, on an ongoing basis, known and as yet unknown victim-survivors of child sexual abuse by James Griffin related to the hospital and should nominate a contact person for people who have enquiries.
2. Assistance should include:
    a. outlining what is known about Mr Griffin's offending at the hospital
    b. taking steps to ascertain whether a person is or may be a victim-survivor of Mr Griffin's offending or clearly explaining why this cannot be done.
3. The Department and Launceston General Hospital's communications with known and as yet unknown victim-survivors of Mr Griffin and their families and carers and the broader community should be informed by the principles of open disclosure.
4. Launceston General Hospital should ensure victim-survivors and their families and carers who do not receive individual open disclosure (Recommendation 15.18) still receive a warm referral to trained child sexual abuse counsellors if desired.

Oversight

Recommendation 15.21

The Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to:

a. addressing systemic issues within health services related to child safety
b. incorporating the administration, monitoring and oversight of the Code of Conduct for Unregistered Health Care Workers
c. coordinating with the role of the new Commission for Children and Young People (Recommendation 18.6), and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*.

Chapter 16 – Criminal justice responses

Police responses

Recommendation 16.1

1. The Tasmanian Government should fund and establish specialist units in Tasmania Police, based on the Victorian Sexual Offences and Child Abuse Investigation Teams model, to investigate child sexual abuse and to be based in three locations (Hobart, Launceston and the North West).
2. The specialist police units should:
    a. specialise in the investigation of child sexual abuse, including historical child sexual abuse (and potentially adult sexual assault) but not undertake domestic and family violence work unless it is directly connected to child sexual abuse (or adult sexual assault)
    b. be staffed by police officers who have undertaken specialised professional development (Recommendation 16.3) and members who have trauma-informed training (Recommendation 19.2)
    c. partner with other agencies and support services involved in responding to child sexual abuse to create multidisciplinary teams. These teams do not have to be co-located, although this may be appropriate in some areas
    d. have access to a 'soft' interview room, ideally offsite from police stations and potentially in multidisciplinary centres
    e. be directed to perform other policing duties only in exceptional circumstances and not as part of a unit's usual roster
    f. support the wellbeing of police officers and members working in the specialist unit
    g. develop and implement strategies to engage and build trust with marginalised communities, particularly Aboriginal people and people with criminal histories (Recommendation 16.2).
3. Tasmania Police should measure and report on victim-survivor satisfaction with the operation of the specialist units within two years of establishment and regularly thereafter.

Recommendation 16.2

1. Tasmania Police should establish ways for people to report child sexual abuse online.
2. The Department of Justice and the Department for Education, Children and Young People should review their internal processes to make it easier for people in prison and youth detention to report abuse to the police or other bodies, including online or by phone hotline, and ensure appropriate confidentiality of reports.
3. Specialist police units (Recommendation 16.1) should develop a strategy to engage with 'priority communities', by implementing measures to develop relationships, build trust and encourage reporting of child sexual abuse, and to assist prevention and 'disruptive' policing (Recommendations 9.29 and 9.30).
4. Priority communities include:
    a. Aboriginal communities
    b. people who are or were in prison or youth detention
    c. people who are or were in out of home care (or youth support services).

Recommendation 16.3

Tasmania Police should review its professional development on child sexual abuse to ensure:

a. all police are trained in
    i. the dynamics of sexual abuse and the concept of grooming, and perpetrators' use of these to facilitate a crime
    ii. myths and misconceptions about child sexual abuse and disclosure
    iii. responding to child and adult victim-survivors sensitively and with an understanding of trauma

b. child sexual abuse specialist detectives are trained in
    i. approaches to interviewing child and adult victim-survivors and vulnerable witnesses, including the Whole Story framework (or similar specialist interviewer training)

ii. understanding the vulnerability of specific groups of children (such as those in out of home care and youth detention) and common myths about these children

c. all police receive scheduled and regular refresher training and ongoing professional development.

Recommendation 16.4

1. Tasmania Police should develop and implement quality audit and assurance processes for investigating child sexual abuse offences, including random file sampling.
2. File sampling should:
   a. capture data on how well police are complying with procedures for investigating child sexual abuse offences, including the requirements set out in the Initial Investigation and Notification of Child Sexual Abuse Guidelines
   b. assess whether
      i. contact was made with the person reporting child sexual abuse
      ii. every effort was made to establish the victim's identity and to assess and investigate the report, where appropriate
      iii. a thorough examination of intelligence on Tasmania Police databases was conducted
      iv. cross-agency and interstate requests for information checks were made to determine whether any intelligence held outside Tasmania might assist the investigation
      v. contact details of the investigating officer were provided to the victim, parent, guardian or other support person
      vi. a supervisor confirmed whether the above actions were taken
   c. capture data on the timeliness of investigations
   d. go beyond technical adherence to requirements and assess the overall quality of police investigative responses and outcomes for victim-survivors, including identifying any opportunities for improvement.

Recommendation 16.5

Tasmania Police should:

a. review the adequacy and availability of equipment used to record evidence by video or audio, and ensure this equipment is available in all police facilities where victim statements relating to child sexual abuse are taken

b. ensure specialist child sexual abuse police officers receive training on the use of recording equipment and refresher training if they have not used the equipment for six months or more.

Recommendation 16.6

1. The Department of Health should increase the availability of forensic medical examination services for child victim-survivors of sexual abuse to ensure all child victim-survivors can access an examination with minimal delay. To achieve this, the Department should:

    a. train existing adult sexual assault forensic medical examination services to examine child victim-survivors

    b. ensure, in areas of Tasmania where no sexual assault forensic medical examination services exist, suitably qualified local health professionals are trained and supported to conduct forensic medical examinations for child sexual abuse.

2. At a minimum, the training should include:

    a. an external, recognised qualification in forensic medical examinations

    b. external recognised training in sexual abuse care for children.

Recommendation 16.7

Tasmania Police should:

a. establish a clear, publicly accessible process for reporting and responding to allegations of child sexual abuse against a member of Tasmania Police, including the ability to report to an entity independent of police such as the Integrity Commission

b. expand the domestic violence review panel to cover child sexual abuse and ensure independence in investigations when a member is alleged to have been involved in child sexual abuse.

Prosecutions

Recommendation 16.8

1. The Office of the Director of Public Prosecutions should provide ongoing professional development to staff on child sexual abuse, including:
   a. specialist training on trauma-informed practice
   b. training on issues that children and adult victim-survivors may face in giving evidence and approaches that can be taken to make the process trauma-informed, including the role of witness intermediaries
   c. training on the laws of evidence and procedure that apply in child sexual abuse cases
   d. training on the nature, causes and methods of child sexual abuse and grooming, including addressing common myths about child sexual abuse.
2. The Office of the Director of Public Prosecutions should also explore opportunities with Tasmania Legal Aid and the Law Society of Tasmania for joint training on the dynamics of child sexual abuse and trauma-informed practice.

Offences, evidence and procedure

Recommendation 16.9

The Tasmanian Government should introduce legislation to amend the following provisions in the *Criminal Code Act 1924*:

a. section 125A to remove all language referring to 'maintaining a sexual relationship with a young person' and replace it with words referring to the 'persistent sexual abuse of a child or young person'

b. section 124A (the position of authority offence) to cover indecent acts with or directed at a child or young person under the age of 18 by a person in a position of authority in relation to that child or young person. The offence should

   i. not apply where the person accused of the offending is under the age of 18 at the time of the offence

   ii. qualify as an unlawful sexual act for the purposes of the offence of 'persistent sexual abuse of a child or young person' under section 125A of the *Criminal Code Act 1924*

c. section 125E (the offence of failure by a person in authority to protect a child from a sexual offence) to ensure the offence does not apply to a person who was under the age of 18 at the time of the offence.

Recommendation 16.10

1. The Tasmanian Government should extend the Witness Intermediary Scheme to include children who are under investigation for, or who have been charged with, sexual offences, and fund it to do so.
2. The Tasmanian Government should consider whether legislation should be enacted requiring police to use witness intermediaries in police interviews of children and young people and adults with communication needs (including defendants), relating to sexual offences.

Recommendation 16.11

1. The Tasmanian Government should introduce legislation to amend the *Evidence (Children and Special Witnesses) Act 2001* to simplify the legislation to clarify when special measures are available to adults who are complainants in trials relating to child sexual abuse and allow them to:
    a. have a support person present when they give evidence in court
    b. give their evidence at a special hearing before the trial unless the judge considers that this would be contrary to the interests of justice, regardless of whether the accused consents
    c. be shielded from the view of the accused person by a screen or partition if they choose to give evidence in court.
2. The Tasmanian Government should ensure courts, public defence counsel (such as Tasmania Legal Aid) and the Office of the Director of Public Prosecutions are appropriately funded to carry out this recommendation.

Recommendation 16.12

The Tasmanian Government should:

a. update the audiovisual equipment available to the Supreme and Magistrates Courts

b. discuss with the Supreme and Magistrates Courts ongoing training for relevant staff on using audiovisual equipment.

Recommendation 16.13

The Tasmanian Government should introduce legislation to extend the principles of section 13B of the *Family Violence Act 2004* to sexual assault matters, including child sexual abuse. This will ensure that where a person is acquitted in the Magistrates Court because the prosecution has informed the Court it will not be offering any evidence in support of the charge, the acquittal does not prevent admitting evidence of relationship, tendency or coincidence evidence in a later related matter.

Recommendation 16.14

The Tasmanian Government should, in similar terms to sections 199, 204 and 205 of the *Criminal Procedure Act 2009* (Vic), amend the *Criminal Code Act 1924* (including section 361A) to:

a. allow pre-trial rulings or orders to be made before the accused person has entered a plea

b. provide that such pre-trial rulings or orders are binding on a trial judge, even where a different judge made the order, unless the trial judge considers that would not be in the interests of justice

c. provide that such pre-trial rulings or orders apply at a new trial unless this would be inconsistent with any order or decision made on an appeal or would not be in the interests of justice.

Recommendation 16.15

The Tasmanian Government should introduce legislation to:

a. require trial judges to explain to juries the difficulties child witnesses often face in giving evidence in court, and the distinctive ways in which they give evidence, in cases where the reliability or credibility of a child witness is likely to be in issue, in similar terms to section 44N of the *Jury Directions Act 2015* (Vic)

b. provide that in jury trials of a person accused of a child sexual abuse offence, if a party so requests, the judge must, unless the judge considers there are good reasons for not doing so, direct the jury that

   i. children who have been subjected to child sexual abuse respond in a variety of ways and some children who have been abused do not avoid the alleged perpetrator

   ii. disclosure of abuse may occur over time and not all on one occasion

c. prohibit, in similar terms to section 294AA of the *Criminal Procedure Act 1986* (NSW), a judge in a trial of a person indicted for sexual offences against a child from

   i. warning a jury against convicting the accused person solely because the only evidence is the evidence of the complainant

   ii. directing the jury about the danger of conviction in the absence of corroboration

d. amend the *Evidence Act 2001*, in similar terms to section 52 of the *Jury Directions Act 2015* (Vic), to require a trial judge who considers that delay in complaining is likely to be raised in a trial for a child sexual abuse offence to inform the jury that

   i. people react differently to sexual abuse and there is no typical, proper or normal response to a sexual offence

   ii. some people may complain immediately to the first person they see, while others may not complain for some time, and others may never make a complaint

   iii. it is common for a person to delay making a complaint of sexual abuse, particularly if it occurred when they were a child

   iv. there may be good reasons why a person may not complain, or may delay complaining about sexual abuse

e. amend the *Evidence Act 2001* to provide that the warnings and directions can be

    i. given by a judge to the jury at the earliest opportunity, such as before the evidence is called or as soon as practicable after it is presented in the trial

    ii. repeated by the judge at any time during the trial

    iii. given by the judge's own motion, or if requested by either party before the trial or at any time during the trial.

Recommendation 16.16

The Tasmanian Government should:

a. fund the Supreme Court to support the professional development of judicial officers on the dynamics of child sexual abuse and trauma-informed practice

b. consider introducing legislation dealing with the responsibility of the Chief Justice to direct the professional development and continuing education and training of judicial officers, in similar terms to section 28A of the *Supreme Court Act 1986* (Vic).

After a conviction

Recommendation 16.17

The Tasmanian Government should ensure preventive programs for adults who are at risk of abusing, or have abused, children are available beyond the custodial setting. These programs should be:

a. properly funded

b. align with the practice guidelines issued by the Association for the Treatment and Prevention of Sexual Abusers

c. include a monitoring and evaluation process.

The language of consent

Recommendation 16.18

1. The Tasmanian Government should introduce legislation to amend section 11A of the *Sentencing Act 1997* to provide that, in determining the appropriate sentence for an offender convicted of a child sexual abuse offence, the acquiescence or apparent consent of the victim is not a mitigating circumstance.
2. The Director of Public Prosecutions should amend its *Prosecution Policy and Guidelines* to make it clear that in child sexual abuse matters where consent is not an element of the offence, then the language of consent should not be used by prosecutors.
3. Professional education for judicial officers (Recommendation 16.16) and prosecutors (Recommendation 16.8) should include challenging the myths and misconceptions about consent in relation to child sexual abuse.

Responses to children and young people displaying harmful sexual behaviours

Recommendation 16.19

We encourage the courts to consider using their powers to direct young people engaging in harmful sexual behaviours who are charged with a criminal offence to specialist therapeutic services.

Monitoring and evaluation

Recommendation 16.20

1. The Department of Justice should:
   a. prioritise collecting and publishing key data about institutional child sexual abuse, including
      i. the number of reports of child sexual abuse made to police
      ii. police, prosecution and court outcomes of reports, and reasons for outcomes, including the reasons why cases did not proceed

   iii. the time between reporting, charging or a decision not to progress, and prosecution

   iv. whether the abuse took place in an institutional setting

   v. basic demographics of victim-survivors and alleged perpetrators (for example, age, gender and Aboriginal status)

   vi. trends in relation to particular groups, including Aboriginal people

b. support the Office of the Director of Public Prosecutions to improve its data collection for child sexual abuse cases so it can effectively monitor

   i. the cases on which police seek advice, that proceed to court and that are discontinued, including the reasons for discontinuance

   ii. the number, type and success rate of appeals in child sexual abuse matters

c. cause periodic surveys to be conducted and published with victim-survivors of child sexual abuse on their experience and satisfaction with the criminal justice system, including on whether the victim-survivor

   i. felt listened to

   ii. felt believed

   iii. understood the process

   iv. was kept informed of the progress of the case.

2. The Sentencing Advisory Council should periodically review trends in sentencing for child sexual abuse offences in Tasmania and compare them with sentencing outcomes for equivalent offences in other Australian jurisdictions.

Chapter 17 – Redress, civil litigation and support

The National Redress Scheme

Recommendation 17.1

1. The Tasmanian Government should ensure victim-survivors of child sexual abuse in Tasmanian Government institutions have access to a redress scheme irrespective of when the abuse occurred, when they were born or whether they have committed a serious offence.
2. To achieve this outcome, the Tasmanian Government should advocate at a national level for:
   a. the National Redress Scheme to apply to child sexual abuse in institutions experienced on or after 1 July 2018, with no specified closing date for applications
   b. changes to the National Redress Scheme that will allow access to redress for people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence.
3. If the National Redress Scheme is not extended, the Tasmanian Government should itself establish a redress scheme for victim-survivors of child sexual abuse in Tasmanian Government institutions, with no specified closing date for applications to be made.
4. The design and operation of any Tasmanian redress scheme should:
   a. ensure delays are minimised and that applications for redress are handled in a sensitive and trauma-informed manner
   b. incorporate relevant recommendations made in the *Second Year Review of the National Redress Scheme*
   c. make it available to people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence
   d. allow information to be shared to reduce current risk to children wherever possible, and to facilitate disciplinary action and reporting 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* (Recommendation 12.5).

Civil litigation

Recommendation 17.2

1. The Tasmanian Government should ensure all lawyers who act for the Tasmanian Government in civil claims relating to child sexual abuse receive regular professional development on:
    a. the nature and effects of child sexual abuse, including institutional child sexual abuse, perpetrator tactics and impacts on victim-survivors
    b. how to consider these effects when victim-survivors are involved in civil litigation processes.
2. The Solicitor-General or the new State Litigation Office should issue and ensure compliance with guidelines relating to:
    a. trauma-informed management of settlement processes and conferences in child sexual abuse cases
    b. whether and when legal professional privilege should be claimed by the Tasmanian Government in relation to medical reports or expert evidence, adopting the principle that generally legal professional privilege should be waived
    c. making apologies before reaching a final settlement.

Recommendation 17.3

1. The Attorney-General should issue guidelines to clarify the respective roles of the Solicitor-General and the new State Litigation Office, departmental secretaries and other agency heads where Tasmanian government agencies are engaged in the conduct and settlement of civil litigation arising from allegations of child sexual abuse.
2. The Treasurer's Instruction relating to obtaining external legal advice should be amended to:
    a. make it consistent with the Attorney-General's guidelines on civil litigation arising from allegations of child sexual abuse
    b. specify the circumstances in which departmental secretaries and other agency heads should be able to seek external legal advice on matters related to child sexual abuse.

Apologies

Recommendation 17.4

The Tasmanian Government should ensure individual victim-survivors of child sexual abuse who request an apology receive one. Proactive steps should also be taken to offer an apology to victim-survivors who make contact in relation to their abuse. The apology should include:

a. the opportunity to meet with a senior institutional representative (preferably the Secretary) and receive an acknowledgment of the abuse and its impact

b. information about the victim-survivor's time in the institution

c. information about what steps the institution has taken or will take to protect against further sexual abuse of children, if asked.

Recommendation 17.5

The Tasmanian Government should introduce legislation to amend the *Civil Liability Act 2002* to ensure that an apology in relation to child sexual abuse can be made without amounting to an admission of liability.

Support for victims of crime

Recommendation 17.6

The Department of Justice should ensure that:

a. in relation to claims for financial assistance under the Victims of Crime Assistance Scheme, delays are minimised and applications for compensation are handled in a sensitive and trauma-informed manner

b. staff in Victims Support Services receive regular professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner

c. people being considered for appointment as Criminal Injuries Compensation Commissioners are required to take part in professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner before their appointment and regularly thereafter.

Recommendation 17.7

The Tasmanian Government should introduce legislation to amend the *Victims of Crime Assistance Act 1976* to create a right of review on the merits by the Tasmanian Civil and Administrative Tribunal in relation to a decision of the Criminal Injuries Compensation Commissioners:

a. to refuse financial assistance to a victim-survivor of child sexual abuse

b. about the amount of financial assistance to which a victim-survivor of child sexual abuse is entitled.

Access to information and records

Recommendation 17.8

1. The Tasmanian Government should review and reform the operation of the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to ensure victim-survivors of child sexual abuse in institutional contexts can obtain information relating to that abuse. This review should focus on what needs to change to ensure:

   a. people's rights to obtain information are observed in practice

   b. this access is as simple, efficient, transparent and trauma-informed as possible.

2. The review should consider reforms to the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to:

   a. include an explicit presumption in favour of disclosure in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*

   b. embed the public interest test in specific exemptions in the *Right to Information Act 2009*, tailored to those exemptions

   c. streamline the interface between the *Right to Information Act 2009* and *Personal Information Protection Act 2004* to overcome what has, by default, become a two-step process to obtain personal information

   d. require that a personal information custodian under the *Personal Information Protection Act 2004* 'must provide' rather than 'may provide' personal information upon request from an individual who is the subject of that information, subject to any appropriate exemptions to that requirement

e. include a 'reasonableness' test in the *Right to Information Act 2009* as part of the assessment of whether to withhold personal information relating to a person or third party other than the person making the request for information

f. strengthen and streamline internal and external review processes in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*, with a focus on options to enforce decisions of the Ombudsman and to apply for review by the Tasmanian Civil and Administrative Tribunal

g. provide an automatic fee waiver for right to information applications relating to child sexual abuse made under the *Right to Information Act 2009* by victim-survivors or a person acting on their behalf.

3. The Tasmanian Government should consider centralising management of access to information processes in a specialist unit or department, supported by access to information liaison officers located in government departments and agencies.

4. The Tasmanian Government should provide funding to government departments, agencies and the Ombudsman, as the case may be, to:

   a. ensure access to information requests are processed within statutory timeframes

   b. speed up external review of right to information decisions

   c. provide trauma-informed training to the Tasmanian State Service in relation to victim-survivor access to information (Recommendation 19.2).

Chapter 18 – Overseeing child safe organisations

Community-wide prevention strategies

Recommendation 18.1

The Tasmanian Government should continue to advocate for Tasmania to receive the full benefit of Australian Government prevention strategies, including under the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

Creating child safe organisations

Recommendation 18.2

All organisations engaging in child-related activities should voluntarily comply with the National Principles for Child Safe Organisations (as reflected in Tasmania's Child and Youth Safe Standards) to the greatest extent possible, regardless of whether they are legislatively bound to do so or when their legislative obligations commence.

Recommendation 18.3

The Tasmanian Government should ensure the Ombudsman is prescribed as an entity for the purposes of disclosure of information under section 40 of the *Child and Youth Safe Organisations Act 2023*.

Child and Youth Safe Organisations Act 2023

Recommendation 18.4

The Tasmanian Government, in implementing the *Child and Youth Safe Organisations Act 2023*, should ensure:

a. the functions of the Independent Regulator and Deputy Independent Regulator under the Act are embedded within the new Commission for Children and Young People (Recommendation 18.6)

b. the Commission is sufficiently resourced to enable it to effectively perform these regulatory functions

c. the Commission has access to government data systems such as those held by Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme to enable systematic and proactive monitoring and that those agencies have access to the Commission's data, where appropriate.

Recommendation 18.5

The Tasmanian Government should ensure its independent three-year review of the *Child and Youth Safe Organisations Act 2023* has a particular focus on:

a. whether the Independent Regulator is sufficiently resourced and empowered to perform its functions effectively, and new or additional resourcing, functions and powers are necessary to support compliance

b. how effectively the Independent Regulator is working with other agencies, including the Ombudsman or other oversight bodies, Registrar of the Registration to Work with Vulnerable People Scheme, Tasmania Police, professional regulatory bodies and other peak bodies, to support compliance, share information and manage active risks to children and young people

c. how organisations captured by the Child and Youth Safe Standards and the Reportable Conduct Scheme have experienced the new regulatory requirements, and in particular whether they have felt sufficiently supported to comply

d. analysing data emerging from the operation of the schemes, particularly as they relate to complaints and notifications and trends within and across sectors

e. whether the Universal Principle requiring organisations to uphold cultural safety is achieving its intended objective, and whether it should become an additional Child and Youth Safe Standard, mirroring the approach in Victoria

f. whether any further legislative changes are required to ensure appropriate information sharing between the Independent Regulator and other agencies.

Oversight and safeguards supporting a child safe system

Recommendation 18.6

1. The Tasmanian Government should establish a statutory Commission for Children and Young People, which includes the following roles, each appointed for a term of five years:

   a. a Commissioner for Children and Young People

   b. a Commissioner for Aboriginal Children and Young People

   c. a Child Advocate (Deputy Commissioner).

2. The Commission for Children and Young People should, in addition to the functions of the current Commissioner for Children and Young People under the *Commissioner for Children and Young People Act 2016*, have the following functions:

   a. educating relevant entities on the Child and Youth Safe Standards and overseeing and enforcing compliance with those standards as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

   b. administering the Reportable Conduct Scheme as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

   c. administering the independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities (Recommendations 9.34 and 12.36)

   d. advocating for individual children in out of home care, youth detention and other residential youth justice facilities

   e. monitoring the operation of the out of home care and youth justice systems and the provision of out of home care and youth justice services to children (Recommendations 9.38 and 12.38)

   f. conducting inquiries into the out of home care and youth justice systems and the services provided to individual children in those systems, including own-motion inquiries (Recommendations 9.38 and 12.38)

   g. making recommendations to government for out of home care and youth justice system improvements

   h. promoting the participation of children in out of home care and youth justice in decision making that affects their lives

   i. upholding and promoting the rights of children in the out of home care and youth justice systems.

3. The Commission for Children and Young People should have all necessary powers to perform its functions.

Recommendation 18.7

The Tasmanian Government should ensure the process for appointing future Commissioners and Deputy Commissioners for Children and Young People adopts the following:

a. future Commissioners 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 vulnerable children

b. the recruitment process for these roles include a non-partisan adult selection panel with at least one member external to the Tasmanian State Service, and a separate children's selection panel

c. the adult and children's selection panels for the role of Commissioner for Aboriginal Children and Young People have a majority of Aboriginal members

d. 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 with at least two members in Parliament.

Recommendation 18.8

The Tasmanian Government should ensure the Commission for Children and Young People is separately and directly funded, rather than through the Department for Education, Children and Young People. Any funding arrangements or conditions should be structured to ensure the Commission has power to control its budget and staffing.

Recommendation 18.9

A joint standing committee of the Tasmanian Parliament should oversee the performance and proper execution of functions of the Commission for Children and Young People.

Other oversight and regulatory bodies

Recommendation 18.10

1. The Integrity Commission and Ombudsman should develop a publicly available policy for complaints related to child sexual abuse which explains the circumstances in which complaints may be referred back to the agency that is the subject of the complaint for investigation.
2. The Integrity Commission and Ombudsman should consult the complainant on the intended approach to handling the complaint, including referring the complaint back to the relevant agency.

Recommendation 18.11

The Tasmanian Government should implement Recommendation 11 of the Independent Reviewer's 2016 Report *Independent Review of the Integrity Commission Act 2009*, which would oblige public authorities to notify the Integrity Commission of any allegations of serious misconduct.

Recommendation 18.12

1. The Tasmanian Government should introduce legislation or regulations to provide statutory guidance to the Registrar of the Registration to Work with Vulnerable People Scheme on the factors to be considered when conducting risk assessments in respect of applications for registration, suspension or cancellation pursuant to the *Registration to Work with Vulnerable People Act 2013*.
2. The statutory guidance should provide that (among other things):
    a. the assessment of unacceptable risk is a predictive exercise that is not necessarily capable of empirical proof nor subject to a particular standard of proof such as 'the balance of probabilities'
    b. the assessment of unacceptable risk of harm to a child or children requires determination of two separate questions, without conflation, namely
        i. whether or not an allegation or allegations of previous harm to vulnerable people are proven on the balance of probabilities, and

ii. whether or not an unacceptable risk of harm is demonstrated regardless of whether there is a finding, on the balance of probabilities, that previous harm occurred

c. the Registrar is not limited in the factors they can consider in assessing unacceptable risk, including information that suggests a person's tendency to cause harm, as the ultimate determination of unacceptable risk is a predictive exercise

d. when the Registrar is considering suspending a person's registration, the focus on the prospective risk that a person may pose to children should have a lower evidentiary threshold, noting further assessment will likely occur prior to a decision to cancel registration or otherwise

e. once the Registrar makes a determination that a person poses an unacceptable risk to a child or young person, irrespective of other factors (such as employment or mental health), that person's registration must be refused, suspended or cancelled (as the case may be).

Recommendation 18.13

1. The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* and related statutory instruments to replace the Administrative Appeals Division of the Magistrates Court with the Tasmanian Civil and Administrative Tribunal as the forum for administrative reviews of decisions under the Act.

2. The Tasmanian Government should:

   a. introduce legislation or regulations to require the Tasmanian Civil and Administrative Tribunal to support Tribunal members who hear administrative reviews of decisions under the *Registration to Work with Vulnerable People Act 2013* to have the knowledge, skills, experience and aptitude to deal with each matter, including in relation to child sexual abuse, neglect and family violence

   b. provide sufficient funding to the Tribunal to support members to gain this knowledge, skills, experience and aptitude.

Recommendation 18.14

1. The Commission for Children and Young People, the Registrar of the Registration to Work with Vulnerable People Scheme, the Integrity Commission and the Ombudsman should work jointly to develop a user-friendly guide for the general public, which describes:
    a. how each of these agencies can assist with complaints and concerns about how organisations respond to child sexual abuse
    b. the process these agencies will adopt in responding to reports, complaints and concerns, including what outcomes these agencies are empowered to achieve
    c. how information provided by a person lodging a report, complaint or concern will be shared and managed
    d. that 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
    e. pathways for raising concerns about the way any of these agencies respond to reports, complaints or concerns.
2. A child and youth-friendly version of the guide should also be developed and should be publicised and distributed widely in schools, out of home care, youth justice and health settings.
3. Both guides should be available on each of the agencies' websites and form part of their child safety community education and engagement activities.
4. While the Commission for Children and Young People should be promoted as the key agency for receiving reports, complaints or concerns relating to conduct towards children, people should be able to raise reports, complaints or concerns with any of these agencies and these agencies should ensure the matter is appropriately referred (the 'no wrong door' approach).

Recommendation 18.15

The Commission for Children and Young People, the Integrity Commission, the Ombudsman and the Registrar of the Registration to Work with Vulnerable People Scheme should develop a formal memorandum of understanding relating to the management and oversight of reports, complaints and concerns relating to child sexual abuse and information sharing. The memorandum of understanding should:

a. define the roles, responsibilities, functions and limitations of each agency and describe where these overlap or intersect

b. require 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

c. provide 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.

Chapter 19 – A coordinated approach

Developing a child sexual abuse reform strategy

Recommendation 19.1

1. The Tasmanian Government should develop a whole of government child sexual abuse reform strategy for preventing, identifying and responding to child sexual abuse, including child sexual abuse in institutions and harmful sexual behaviours. The strategy should:

   a. describe the system that Tasmania seeks to achieve, including the component parts of that system, how Tasmanians will know it is working, and the role of key initiatives, reforms and recommendations in achieving the intended outcomes

   b. be separate from, but complement, the Government's Family and Sexual Violence Action Plan

   c. be informed by the voices of children and young people and adult victim-survivors of child sexual abuse (Recommendation 19.5)

d. include agreed definitions of child sexual abuse, institutional child sexual abuse and harmful sexual behaviours

e. set out guiding principles and objectives to inform preventing, identifying and responding to child sexual abuse

f. identify the agencies, including statutory bodies and non-government organisations, involved in preventing, identifying and responding to child sexual abuse

g. set out processes through which government agencies, statutory bodies and non-government organisations can consult on child sexual abuse reform

h. set out considerations relevant to particular cohorts of children and young people, including Aboriginal children, children with disability, children with mental illness, children who identify as LGBTQIA+ and children from culturally and linguistically diverse communities

i. outline the sources of funding for key initiatives and reforms set out in the strategy

j. outline the governance, monitoring, review and evaluation arrangements for child sexual abuse reform, including that the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, is responsible for endorsing, overseeing, coordinating and reporting on the strategy and action plan (Recommendation 19.3).

2. The Tasmanian Government should develop an action plan for the implementation of the child sexual abuse reform strategy. The action plan should:

   a. prioritise all recommendations and reforms for implementation over the short, medium and long term and include expected timeframes for implementing each recommendation

   b. identify the role holders and agencies that have responsibility for implementation of each recommendation and reform

   c. describe the actions to be taken to implement the recommendations and reforms, including any milestones, sequencing and dependencies

   d. identify the status of each recommendation and reform (that is, complete, under way or not commenced) and whether it is progressing on time

   e. be endorsed and overseen by the governance structure identified in the strategy.

3. The child sexual abuse reform strategy and action plan should be:
    a. tabled in each House of Parliament
    b. published on a dedicated website
    c. supported by a communication plan that seeks to inform and provide visibility of reform work to stakeholders and the community
    d. periodically reviewed and updated by the Secretaries Board through the Department of Premier and Cabinet.

Trauma-informed government services

Recommendation 19.2

The Tasmanian Government should develop a whole of government approach to professional development on responding to trauma within government and government funded services, as well as statutory bodies, that provide services to children and young people or adult victim-survivors of child sexual abuse.

Establishing a strong governance structure for child safety

Recommendation 19.3

The Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, should be responsible for endorsing, overseeing, coordinating and reporting on the child sexual abuse reform strategy and action plan.

Recommendation 19.4

1. The Premier should, through their performance agreements, ensure Heads of Agencies are responsible for reforms under the child sexual abuse reform strategy and action plan within their portfolio responsibilities.
2. Heads of Agencies should ensure relevant State Service executives are also responsible for implementing the strategy and action plan.
3. The statements of duties for relevant departmental staff should refer to their responsibilities in relation to the strategy and action plan.

Recommendation 19.5

1. The Tasmanian Government should ensure, in setting out the governance structure for the child sexual abuse reform strategy and action plan, that children and young people and adult victim-survivors of child sexual abuse are part of this governance structure through:
   a. the Premier's Youth Advisory Council
   b. the establishment of an advisory group comprising adult victim-survivors of child sexual abuse, including child sexual abuse in institutions, of different ages, backgrounds, cultures, gender identities and geographical locations and parents of child victim-survivors.
2. The Department of Premier and Cabinet should report on the activities of these advisory groups in its annual report.
3. These advisory groups should:
   a. be guided by clear terms of reference that have been developed in consultation with the advisory groups
   b. have a clear purpose and objectives in terms of how they can contribute across the whole of government
   c. receive secretarial support and be adequately funded and resourced
   d. ensure trauma-informed processes apply in their interactions
   e. support and enable members' attendance by covering the costs of travel and expenses, and providing honorariums where appropriate.

Improving information sharing and cross-agency coordination for child safety

Recommendation 19.6

The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* to clarify that, in addition to the duty to report in certain circumstances, any person can notify reportable behaviour to the Registrar of the Registration to Work with Vulnerable People Scheme.

Recommendation 19.7

The Tasmanian Government should review confidentiality and secrecy provisions in Tasmanian legislation, including the *Personal Information Protection Act 2004*, to identify any specific legislative barriers that hinder the sharing of information necessary to protect the safety and wellbeing of children and young people and remove these barriers.

Recommendation 19.8

1. The Department of Premier and Cabinet should lead the development of child safety information sharing, coordination and response guidelines to support government and government funded agencies and statutory bodies to respond to child safety issues. The guidelines should:
    a. set out the principles which guide information sharing, cross-agency coordination and the roles of different services and entities in responding to child safety issues, and require that staff are trained on these issues
    b. identify a process for nominating a lead agency for cross-agency responses to individual child safety issues and set out the lead agency's role and responsibilities
    c. identify a process for setting out the roles and responsibilities of collaborating agencies in responding to child safety issues
    d. explain child safety information-sharing obligations and responsibilities and how staff can fulfil them
    e. set out an escalation and dispute resolution process to resolve disagreements that may arise across agencies
    f. identify resources and professional development opportunities for staff in relation to responding to child safety issues
    g. be subject to periodic review to ensure they remain up to date and accurately reflect best practice cross-agency information sharing and coordination arrangements.
2. The Tasmanian Government should fund the culture change work required to achieve good information-sharing practices.

Chapter 20 – State Service disciplinary processes

The State Service Code of Conduct

Recommendation 20.1

1. The Tasmanian Government should, by introducing legislation or through other means, ensure that the State Service Code of Conduct includes the following binding obligations:

    a. if a state servant's conduct creates an unacceptable risk to the safety and wellbeing of children or young people accessing government and government funded services, the State Service disciplinary framework should apply, and termination, suspension or sanction should be available (including being able to terminate employment based on a loss of confidence)

    b. in relation to child sexual abuse and related conduct, the requirement that state servants must comply with all applicable Australian law is determined on the basis of a balance of probabilities test and does not require a breach of the law to be determined by a court

    c. where a state servant has contact with a child or young person through their work, and an allegation is made of child sexual abuse or related conduct in relation to that child, this contact is sufficient to establish the conduct occurred 'in the course of employment' or, in the case of section 9(14), has a nexus to employment regardless of whether the conduct complained of occurred outside the workplace or outside working hours.

2. The Tasmanian Government should develop policy documents or guidance on the interpretation of the State Service Code of Conduct explaining (among other things):

    a. how the required connection between a state servant's employment and a child and young person should be interpreted in matters that involve child sexual abuse or related conduct

    b. explain that all provisions of the Code of Conduct should be interpreted to prioritise the protection of children.

Recommendation 20.2

1. All Heads of Agencies whose agencies provide services to children should develop a professional conduct policy for the agency's employees that:
    a. explains what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
    b. defines and prohibits child sexual abuse, grooming and boundary violations, in language consistent with the *Child and Youth Safe Organisations Act 2023.*
2. The professional conduct policy should:
    a. 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
    b. provide guidance on identifying behaviours indicative of child sexual abuse, grooming and boundary violations relevant to the particular organisation
    c. 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 and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, or other relevant agencies
    d. provide that not following reasonable directions is a breach of professional standards
    e. provide that a failure to report a breach or suspected breach of the policy may be taken to be a breach of the policy
    f. outline the protections available to individuals who make complaints or reports in good faith
    g. provide and clearly outline response mechanisms for alleged breaches of the policy
    h. 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
    i. cross-reference 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.

3. The professional conduct policies should be:

    a. easily accessible to everyone in the agency and communicated by a range of mechanisms

    b. explained to and acknowledged and signed by all employees

    c. accompanied by a mandatory initial training session and regular refresher training, including as part of professional development training

    d. communicated to children and young people and their families through a range of mechanisms, including publication on the agency's public-facing website.

4. The professional conduct policies should include a specific prohibition on romantic or sexual relationships between an employee and a young person where that employee has been in a position of authority, care or protection with the young person for two years after the young person turns 18 or the employee's position of authority, care or protection has ended, whichever is later. This requirement should operate in addition to any other professional and ethical obligations.

5. Heads of Agencies should ensure the professional conduct policy spells out expected standards of behaviour for volunteers, contractors and sub-contractors, and other adults where relevant to the specific organisation and use appropriate mechanisms to ensure their compliance with the policy.

6. The Tasmanian Government should introduce legislation, or other binding mechanisms, to ensure:

    a. a breach of a departmental professional conduct 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

    b. such a breach does not have to be accompanied by a lawful and reasonable direction for there to be a breach of the Code of Conduct.

Recommendation 20.3

The Tasmanian Government should introduce legislation to ensure that where a finding is made that a State Service employee has committed reportable conduct under the Reportable Conduct Scheme, this also constitutes a breach of the State Service Code of Conduct under section 9 of the *State Service Act 2000*.

Recommendation 20.4

The Tasmanian Government should introduce legislation to ensure the provisions in the professional conduct policies apply to contractors, sub-contractors, volunteers and other adults who have contact with children.

Employment Directions

Recommendation 20.5

1. The State Service should develop guidance material for conducting preliminary assessments to ensure:
    a. they are conducted quickly (within three to five business days after an allegation is received)
    b. the reasons for any delay are documented, a new timeframe set, and the reasons for the delay and the new timeframe are communicated to the parties if applicable in the circumstances
    c. they are confined to a basic gathering of information and do not require evidence of wrongdoing
    d. they do not assess whether the alleged conduct occurred in the course of the employee's State Service employment.
2. Victim-survivors and child witnesses should not normally be interviewed at the preliminary assessment stage to avoid them being interviewed more than once or being interviewed by a person without special skills. If it is necessary to interview a child or young person at this stage, then this should be done in line with clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct. Any such interview should be conducted by individuals who have been trained in child development, child sexual abuse (including taking a Whole Story approach), and trauma-related behaviours.
3. Any engagement with a child or young person during the preliminary assessment stage should be child-centred and trauma-informed.
4. The Child-Related Incident Management Directorate should conduct preliminary assessments in child sexual abuse or related conduct matters.

Recommendation 20.6

The Tasmanian Government should amend Employment Direction No. 4—Suspension to:

a. specify that in matters involving complaints or concerns about child sexual abuse or related conduct of an employee, they may be suspended immediately

b. clarify, to avoid any doubt, that suspension can occur before the start of any disciplinary processes, including preliminary assessments

c. exclude, in matters involving complaints or concerns of child sexual abuse or related conduct, the requirement that the Head of Agency must have a reasonable belief that it is in the public interest to suspend the employee

d. include the safety of children and young people among the matters a Head of Agency must take into account when deciding whether to suspend an employee.

Recommendation 20.7

The Tasmanian Government should ensure investigations into misconduct in relation to child sexual abuse or related conduct by State Service employees of the Department for Education, Children and Young People and the Department of Health under Employment Direction No. 5—Breach of Code of Conduct are conducted by the Child-Related Incident Management Directorate.

Recommendation 20.8

The Tasmanian Government should amend Employment Direction No. 5—Breach of Code of Conduct, as it relates to child sexual abuse or related conduct, to:

a. ensure people making a complaint and children or young people who have been abused have the right to

    i. reply to any factual matters put forward by the alleged abuser

    ii. know the outcome of an investigation

    iii. seek a review of decisions in an appropriate forum

b. clarify timeframes for carrying out investigations, set out the process for seeking an extension of time for an investigation and the considerations involved, and require the granting of, and reasons for, an extension of time be communicated to the parties affected

c. provide that all matters of concern relevant to an employee's conduct with a child or young person pertaining to child sexual abuse or related conduct be treated as potential serious misconduct

d. note the importance, in circumstances where it is appropriate to summarily dismiss an employee for misconduct, of conducting an investigation to identify children who have been harmed and any systemic problems that need to be addressed

e. ensure investigations are conducted by people who have been trained in child development, child sexual abuse (including taking a Whole Story approach) and trauma-related behaviours.

Recommendation 20.9

The Tasmanian Government should maintain a central cross-government register of misconduct concerning complaints and concerns about child sexual abuse and related conduct. This register should contain records of substantiated and unsubstantiated matters, including those that did not proceed to investigation.

Recommendation 20.10

1. The Tasmanian Government should take measures to ensure that misconduct investigations under Employment Direction No. 5—Breach of Code of Conduct in relation to complaints and concerns of child sexual abuse are able to take into account prior substantiated, untested and unsubstantiated complaints, allegations and disciplinary action, in addition to the immediately alleged misconduct.
2. The Tasmanian Government should take measures to ensure that prior allegations (including unsubstantiated allegations) should be considered at various stages of the disciplinary process, including in determining:

a. the process to be used to deal with new allegations

b. whether the conduct occurred on the balance of probabilities, with previous substantiated allegations being given more weight than unsubstantiated allegations

c. if misconduct has occurred

d. the sanction to be applied.

Recommendation 20.11

1. The Head of the State Service should monitor and publicly report annually on the management of misconduct matters related to child sexual abuse or related conduct.

2. Heads of Agencies should report quarterly to the Head of the State Service on all misconduct matters related to child sexual abuse or related conduct, substantiated and unsubstantiated.

Recommendation 20.12

The Tasmanian Government should introduce legislation to amend Employment Direction No. 6—Inability to provide for:

a. a simplified process that applies to matters where the employee no longer has an essential employment requirement (for example, no registration under the *Registration to Work with Vulnerable People Act 2013*)

b. powers to immediately terminate a person's employment if the employee no longer meets an employment requirement for working with children or young people

c. any interview with a child or young person in line with Employment Direction No. 6—Inability to be subject to the same considerations as should apply under clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct (Recommendation 20.8).

Recommendation 20.13

1. The Head of the State Service should issue guidance on State Service disciplinary processes that contains key principles and procedures to be followed. This guidance should include information on:
    a. the steps involved in the process of dealing with disciplinary matters
    b. maintaining confidentiality
    c. setting timeframes for investigations and communicating timeframes to the parties
    d. preliminary assessments
    e. employee suspensions, in particular where matters are alleged to involve child sexual abuse
    f. considerations when interviewing children
    g. an employee's inability to perform a role due to the loss of employment requirements
    h. the rights of an employee and any complainant.
2. This guidance should be developed in line with relevant child safety considerations, relevant recommendations of this Commission of Inquiry and the Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector*.

Cultural change

Recommendation 20.14

The Tasmanian Government should allocate funding for initiatives aimed at cultural change and awareness raising to promote a shared understanding and application of disciplinary processes across the State Service in a manner that ensures the safety and wellbeing of children at risk of child sexual abuse or related conduct.

Role of the Tasmanian Industrial Commission

Recommendation 20.15

The Government should fund the Tasmanian Industrial Commission to enable its members to attend training on child sexual abuse either locally or through any relevant interstate program or training, such as the programs offered by the Judicial College of Victoria.

Chapter 21 – Therapeutic services

Improving the therapeutic service system

Recommendation 21.1

1. The Department of Premier and Cabinet should lead, coordinate and fund a therapeutic service system for child and adult victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.
2. The Department should ensure the therapeutic service system:
    a. addresses service gaps and provides coordination of services, appropriate coverage and equitable access to quality services
    b. is easily understood and accessible to the public, state servants and other mainstream service providers.
3. The Department, in leading this work, should consult with:
    a. any relevant government departments, including the Department for Education, Children and Young People, the Department of Health and Tasmania Police
    b. sexual assault and abuse counselling services
    c. the Premier's Youth Advisory Council and the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)
    d. the peak body for the sexual assault service system (Recommendation 21.3).
4. The Tasmanian Government should ensure funding agreements with non-government specialist services include appropriate governance requirements, sexual abuse service standards, service evaluation and child safe accreditation.

Recommendation 21.2

1. The Tasmanian Government should conduct an independent process and outcomes evaluation for the pilot multidisciplinary Arch centres and any future centres after three years of operation to inform the Government of any systems improvements that could be made to the centres and whether they have resulted in improvements in client outcomes. The evaluation should incorporate:
    a. an evaluation and data outcomes framework established during the first year that includes required baseline and outcomes data for clients receiving services through the Arch centres, and considers how Arch centre outcomes can be compared with the outcomes of cases that have not received an Arch centre response
    b. the collection of data in line with the data outcomes framework in the first year
    c. the storing and retention of data in a format that can be provided to the independent evaluators.
2. The evaluation and data outcomes framework should include outcome measures for adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.
3. The Tasmanian Government should ensure multidisciplinary centres are not the sole response to the therapeutic needs of adult and child victim-survivors of child sexual abuse.

Recommendation 21.3

1. The Tasmanian Government should establish a peak body for the sexual assault service system, including therapeutic interventions for children who have engaged in harmful sexual behaviours, to:
    a. ensure the needs of adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours are met by the sexual assault service system
    b. represent sexual assault service providers in a coordinated way
    c. share evidence and experience
    d. develop or identify practice standards for sexual assault services and interventions for child sexual abuse and harmful sexual behaviours

e. coordinate service delivery for victim-survivors

f. advocate for improvements in the sexual assault service system.

2. This peak body for the sexual assault service system should be distinct from, but work in cooperation with, a family violence peak body.

Recommendation 21.4

1. The Tasmanian Government should increase the funding for free or low-cost sexual assault counselling services to:

   a. reduce waiting times to no longer than four weeks for victim-survivors, regardless of where they live in Tasmania

   b. enable fortnightly access to sexual assault counselling in Ashley Youth Detention Centre

   c. assist peer support groups.

2. The Department of Premier and Cabinet should adopt strategies to increase the number of professionals with skills to provide therapeutic responses to abuse-related trauma to address the challenge in attracting and retaining sufficient suitably qualified staff to fill vacancies and meet the need for therapeutic responses to child sexual abuse.

Recommendation 21.5

The Tasmanian Government should increase the capacity of the Victims of Crime Service by:

a. increasing the number of counsellors available in each of the Victims of Crime Service offices to at least three in southern Tasmania, two in northern Tasmania and two in the North West

b. promoting the availability of the Victims of Crime Service counselling service to victim-survivors of sexual assault.

Recommendation 21.6

1. The Tasmanian Government should ensure that the needs of particular groups of victim-survivors are met by the therapeutic service system and related contracting of services, including the needs of:
    a. children who are victim-survivors or have displayed harmful sexual behaviours (Recommendation 21.8)
    b. victim-survivors with disability or mental illness
    c. victim-survivors who identify as LGBTQIA+
    d. male victim-survivors
    e. victim-survivors who are from culturally and linguistically diverse backgrounds.
2. The Tasmanian Government should consult on the therapeutic service system with relevant stakeholder groups, including the Interim Disability Commissioner, community groups and representative bodies.

Recommendation 21.7

The Tasmanian Government should improve healing services for Aboriginal victim-survivors and their families and communities by:

a. fully resourcing and supporting recognised Aboriginal organisations across the state to design, develop and deliver Aboriginal-led healing approaches targeted to victim-survivors of child sexual abuse

b. ensuring Aboriginal representation on the boards of management or in the executive structures of sexual assault services.

Strengthening services for children who have displayed harmful sexual behaviours

Recommendation 21.8

1. The Tasmanian Government, in collaboration with key stakeholders, should develop a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours. The framework should:

a. agree on a common definition and understanding of harmful sexual behaviours, including adopting a recognised, contemporary continuum of sexual behaviours from 'developmentally expected' to 'harmful'

b. use an evidence-informed framework for understanding, preventing, identifying and responding to harmful sexual behaviours

c. clarify the roles and responsibilities of the various agencies and departments involved in preventing and responding to the full continuum of harmful sexual behaviours, including programs delivered by non-government providers

d. meet the needs of particular groups of children (Recommendation 21.6)

e. include structures to support ongoing engagement with emerging evidence regarding harmful sexual behaviours

f. include an evaluation framework.

2. The Tasmanian Government should ensure the therapeutic service system for children who have displayed harmful sexual behaviours:

   a. provides sufficient therapeutic services that can be accessed in a timely manner

   b. ensures timely access to therapeutic services for all children who need them, regardless of their age, identity or location in the state (including in youth detention)

   c. ensures specialist interventions for children with disability

   d. ensures all providers of therapeutic interventions for harmful sexual behaviours have Aboriginal representation in their governance structure.

3. The Tasmanian Government should provide ongoing and increased funding for specialist therapeutic interventions for harmful sexual behaviours that:

   a. ensures children who have displayed abusive or violent harmful sexual behaviours and their families need not wait more than two weeks for support when therapeutic treatment is required

   b. provides an advisory service for child-facing organisations, such as independent schools, childcare, disability and at-risk youth services and Tasmania Police (this service is not intended for the Department for Education, Children and Young People, which will have access to an internal Harmful Sexual Behaviours Support Unit (Recommendation 9.28))

   c. contributes to the statewide plan for preventing harmful sexual behaviours and its agencies' responses to children who have displayed such behaviours.

Recommendation 21.9

The Tasmanian Government should introduce legislation to amend the *Children, Young Persons and Their Families Act 1997* and the *Youth Justice Act 1997* to:

a. give the Magistrates Court explicit power to order that a child who has displayed harmful sexual behaviours (and their family) engage in a therapeutic intervention for harmful sexual behaviours

b. ensure the Magistrates Court has the power to divert from the criminal justice system a child who has been charged with a criminal offence and who has engaged in harmful sexual behaviours, by adjourning the criminal proceeding to enable the child to engage in a therapeutic intervention, and discharging the child where the intervention has been completed successfully.

Recommendation 21.10

Tasmania Police and the Department for Education, Children and Young People should update the *Keeping Children Safe Handbook* to reflect the Tasmanian Government's statewide framework and plan for addressing harmful sexual behaviours, including by:

a. modifying the language used when discussing children who have displayed harmful sexual behaviours to align with the definitions developed through the National Office of Child Safety

b. clarifying the roles and responsibilities of the two agencies in responding to incidents involving harmful sexual behaviours, including the conditions under which each agency will lead the response

c. clarifying the involvement of specialist therapeutic services in responses to incidents.

Chapter 22 – Monitoring reforms

Recommendation 22.1

1. The Tasmanian Government should introduce legislation to establish and fund an independent Child Sexual Abuse Reform Implementation Monitor to:

   a. monitor and report to Parliament annually on the implementation of

      i. the recommendations of this Commission of Inquiry

      ii. any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse that were accepted by the Tasmanian Government and have not been implemented

      iii. the recommendations of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse

   b. undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations identified above, especially the impact on the safety and wellbeing of children in government and government funded institutions and victim-survivors of child sexual abuse in institutional contexts.

2. Independent evaluations should enable assessment of change over time and involve:

   a. identifying an evaluation framework and baseline data requirements within the first year of the appointment of the Implementation Monitor

   b. commencing collection of data identified in the evaluation framework as soon as possible after the evaluation framework has been developed

   c. assessing the change against the evaluation framework at five- and ten-year intervals following the tabling of this report

   d. making independent evaluations publicly available.

3. The Tasmanian Government should protect the independence of the Implementation Monitor by:

   a. appointing the Implementation Monitor for a fixed term that cannot be prematurely terminated except in extraordinary circumstances

   b. maintaining the role of the Implementation Monitor until implementation of the recommendations identified above is substantively complete

   c. separately and directly funding the Implementation Monitor, rather than through a line agency.

4. The Tasmanian Government, through the Secretaries Board, should be required to report to:
   a. the Implementation Monitor as requested and in the form required by the Implementation Monitor
   b. the public on its implementation and reform activity through the Department of Premier and Cabinet's annual report.
5. The Implementation Monitor should consult as required with:
   a. the Premier's Youth Advisory Council
   b. the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)
   c. the peak body for the sexual assault service system (Recommendation 21.3)
   d. the institution-specific advisory groups established within Tasmanian government agencies (Recommendations 9.6, 12.8 and 15.7).

Findings

Chapter 11 – Case studies: Children in youth detention

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

Finding—For decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse

Case study 2: Harmful sexual behaviours

Finding—In August 2019, Henry (a pseudonym) was exposed to an unacceptable risk of harm and experienced preventable harm at Ashley Youth Detention Centre[86]

Finding—In August 2019, Max (a pseudonym) was exposed to an unacceptable risk of harm at Ashley Youth Detention Centre[87]

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

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

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[88]

Finding—The 20 January 2020 issues briefing on concerns regarding Ray at Ashley Youth Detention Centre was inadequate and incomplete

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

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

Finding—The Department should have fully investigated allegations that staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees

Finding—There is a lack of consistent policy and practice at Ashley Youth Detention Centre on unit placements

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

Case study 3: Isolation in Ashley Youth Detention Centre

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

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

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

Finding—Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices

Case study 4: Use of force in Ashley Youth Detention Centre

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

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

Case study 5: A response to staff concerns about Ashley Youth Detention Centre

Finding—The Department should not have conducted the Preliminary Assessment and this reflects systemic problems

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

Finding—The delay in the Preliminary Assessment was not acceptable and risked exposing children to ongoing harm

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[89]

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

Case study 6: A complaint by Max (a pseudonym)[90]

Finding—Ashley Youth Detention Centre and the Department did not respond to Max's allegation appropriately

Case study 7: Allegations of child sexual abuse against staff at Ashley Youth Detention Centre

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

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[91]

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[92]

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

Finding—Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre

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

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

Chapter 14 – Case studies: Children in health services

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

Case study 2: Response to complaint about Dr Tim (a pseudonym)[94]

Finding—Dr Peter Renshaw failed to comply with Launceston General Hospital's protocol for reporting and management of cases of suspected child abuse

Finding—Dr Peter Renshaw failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations

Finding—Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while Zoe Duncan's allegations were investigated

Finding—Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure and not waited until June 2002

Finding—The procedure used by Child Safety Services to investigate Zoe Duncan's allegations against Dr Tim was inappropriate and not consistent with best practice at the time

Finding—Child Safety Services carried out an inadequate investigation of Zoe Duncan's allegations, which affected subsequent investigations

Finding—Tasmania Police carried out an inadequate investigation of Zoe Duncan's allegations

Finding—Launceston General Hospital failed in its overall response and did not offer appropriate support to Zoe Duncan and her family

Case study 3: James Griffin

Finding—Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years

Finding—Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012

Finding—Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained

Finding—Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required

Finding—Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services

Finding—Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him

Finding—Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made

Finding—The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings

Finding—Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015

Finding—Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation

Finding—Launceston General Hospital failed to manage the risks posed by James Griffin

Finding—Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported

Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin

Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct

Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem

Finding—Launceston General Hospital did not have a robust system for managing complaints involving child safety

Finding—Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies

Finding—James Griffin had the ability to take and misuse medications from Launceston General Hospital

Finding—The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective

Finding—Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin

Finding—Launceston General Hospital did not have clear accountabilities for child safety

Finding—Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019

Finding—The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure

Finding—Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised about it by Tasmania Police on 29 October 2019

Finding—The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff

Finding—Dr Peter Renshaw misled the Secretary of the Department about James Griffin

Finding—The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

Finding—The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review

Misconduct finding—Dr Peter Renshaw misled our Commission of Inquiry about his state of knowledge

Finding—Launceston General Hospital should ensure open disclosure processes are trauma-informed

Finding—Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure

Finding—James Bellinger should not have taken the statement from Stewart Millar

Glossary

Term	Definition
boundary breaches / boundary violations	Behaviours that cross the line between a professional and personal relationship. For example, a teacher providing a student with personal contact details.
child / young person	A person below the age of 18 years, as defined by the United Nations Convention on the Rights of the Child.[95] We use the terms ‘child’ and ‘young person’ depending on the context. We recognise that many older children prefer being referred to as young people but, at times, using this term may minimise young people’s vulnerability and legal status as children, particularly in the context of youth detention.
‘child-facing’ institutions or services	Institutions that provide services directly to children (such as schools), as distinct from more operational services (such as human resources) where any contact with children is incidental.

Term	Definition
child safe institution / child safe organisation	An institution that puts children first and ensures their safety. It 'consciously and systematically: • Creates an environment where children's safety and wellbeing is at the centre of thought, values and actions. • Places emphasis on genuine engagement with and valuing of children and young people. • Creates conditions that reduce the likelihood of harm to children and young people. • Creates conditions that increase the likelihood of identifying any harm. • Responds to any concerns, disclosures, allegations or suspicions of harm'.[96] We use 'child safe institution' and 'child safe organisation' interchangeably.
Child and Youth Safe Standards	Tasmania adopted Child and Youth Safe Standards in the *Child and Youth Safe Organisations Act 2023*.[97] Under this Act, organisations must also comply with an embedded Universal Principle requiring regulated entities to 'provide an environment that ensures that the right to cultural safety of children who identify as Aboriginal or Torres Strait Islander is respected'.[98] Our references to the new Child and Youth Safe Standards should be read as inclusive of the Universal Principle.
Child Safety Service / Child Safety Services	Formerly known as Child Protection Services, this is the division of Children, Youth and Families (part of the Department for Education, Children and Young People) that acts to 'protect children and young people who are at risk of abuse or neglect'.[99] It investigates child welfare concerns, including child sexual abuse, and is responsible for children in out of home care. We use 'Child Safety Service' and 'Child Safety Services' interchangeably.
child sexual abuse	Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the touching of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, touching of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child, and any related matters.[100]

Term	Definition
child sexual exploitation	A form of child sexual abuse where: 'a child is manipulated or coerced to participate in a sexual activity in exchange for, or the promise of, an incentive. This can include incentives such as food, accommodation, clothing, drugs, alcohol, cigarettes or money. It can also include incentives such as love, affection, or safety. Child sexual exploitation is a distinct form of child sexual abuse because of this notion of exchange or reward'.[101]
Counsel Assisting	Lawyers appointed to assist a commission of inquiry. They can perform several roles, including speaking and asking questions at hearings.
detainee / child or young person in detention	A child or young person detained in a youth detention facility (sometimes referred to as residents). We use the terms 'child and young person in detention', 'child in detention', or 'young person in detention' but sometimes use 'detainee' for ease of reading.
Employment Directions	Issued by the Minister administering the *State Service Act 2000*, Employment Directions provide instruction on how the State Service must manage State Service employment matters, including suspensions, investigations of alleged breaches of the Code of Conduct and considerations relevant to whether an employee no longer has the ability to perform their role. Employment Directions replaced Commissioner's Directions and a number of Ministerial Directions from 4 February 2013 (some Ministerial Directions are still being replaced).
ex gratia	Something that is done voluntarily rather than as a result of a legal obligation. For example, an ex gratia payment may be made by an institution to someone who has been harmed in some way, as a gesture of goodwill rather than an acceptance of legal liability.
grooming	A form of child sexual abuse, defined in this glossary under 'child sexual abuse'.
harmful sexual behaviours	A form of child sexual abuse that involves: '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'.[102]

Term	Definition
Head of Agency / Heads of Agencies	Leaders of Tasmanian Government agencies, including secretaries of departments and chief executive officers of agencies. A Head of Agency 'leads, and is responsible for, the overall management of communications and its integration with other key functions, particularly policy and program management'.[103] In the context of our Commission of Inquiry, Heads of Agencies are most commonly secretaries of departments.
LGBTQIA+	An inclusive term that recognises people's complexity and diversity, encompassing the entire spectrum of gender fluidity and sexual identities. The letters refer to lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other sexually or gender diverse people.[104]
National Redress Scheme	The scheme that allows victim-survivors to seek financial compensation, counselling and a direct personal response from the institution in which their abuse occurred, without needing to interact with their abuser or pursue criminal or civil claims.[105] The National Redress Scheme was set up by the Australian Government in July 2018 and was given effect in Tasmanian legislation in the same year. Non-government institutions may also join the scheme.[106]
National Royal Commission	Refer to 'Royal Commission into Institutional Responses to Child Sexual Abuse'.
related conduct	In relation to child sexual abuse, any unlawful or improper treatment of children that is, either generally or in any particular instance, connected or associated with child sexual abuse.
reportable conduct scheme	A scheme that monitors how organisations investigate and report on allegations of misconduct towards children, with the requirement to report these allegations to an independent body. In Tasmania, a Reportable Conduct Scheme is being established under the *Child and Youth Safe Organisations Act 2023* that enables people to report neglect or abuse by a worker towards a child to an Independent Regulator.[107]
Royal Commission into Institutional Responses to Child Sexual Abuse / National Royal Commission	The Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') was established on 11 January 2013.[108] The National Royal Commission investigated child sexual abuse in government and non-government institutions across Australia. It released its final report, including 409 recommendations, in 2017.

Term	Definition
Secretary or Secretaries	Refer to 'Head of Agency'.
State Service	Tasmanian government departments and institutions that develop and deliver government policies, programs and services. Employment in the State Service is established under the *State Service Act 2000*.[109] People who work in the State Service are sometimes called state servants or public servants, as well as government employees, staff or workers.
State Service Code of Conduct	The State Service Code of Conduct outlines how employees of the State Service are expected to behave.[110]
trauma-informed	A way of understanding people and their interactions that is based on an awareness of trauma and its effects, as well as behaving in ways that demonstrate this understanding. This applies to how individuals, organisations and wider society can recognise and respond to people who may have experienced trauma. The core trauma-informed principles are safety, trust, choice, collaboration, empowerment and respect for diversity.[111]
victim-survivor	Someone who has been sexually abused as a child. When we use the term 'victim-survivor', it is to recognise a person's experience and is not a legal determination. For ease of reading, we use the term 'victim-survivor'. We recognise that some people prefer 'survivor' because of the resilience and empowerment associated with the term, and because they do not identify as victims. We also recognise that some people who have experienced abuse do not consider that they 'survived' the abuse and that 'victim' is more appropriate. We also recognise that some people may have died by suicide as a consequence of the abuse they experienced. We acknowledge that 'victim' is more appropriate in these circumstances. We also recognise that some people do not identify with either of these terms, and may prefer terminology such as 'person with lived experience of child sexual abuse'.[112]
2000s, 2010s & 2020s	In this report, we refer to the following time periods: • the '2000s' means the years 2000 to 2009 • the '2010s' means the years 2010 to 2019 • the '2020s' means the decade beginning 2020. To avoid identifying people, we sometimes use 'early', 'mid-' and 'late' with these decades without specifying the relevant years.

Notes

Executive summary

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2 The Attorney-General and Minister for Health implemented an independent investigation into the systems of the Tasmanian Health Service, Department of Health and other relevant Government agencies concerning the management of allegations of child sexual abuse, particularly in the matter of James Griffin: Department of Justice, *Independent Investigation into the THS and the Management of Child Sexual Abuse* (Web Page, 2023) <https://www.justice.tas.gov.au/news_and_events/investigation-into-ths-child-sexual-abuse-allegations>. The Department of Communities initiated an investigation of three current employees of Ashley Youth Detention Centre who were the subject of allegations of abuse. The staff were stood down pending investigation: Roger Jaensch, *Allegations against Staff at AYDC* (Web Page, 2022) <http://www.rogerjaensch.com.au/allegations-against-staff-at-aydc/>. The Minister for Education initiated an independent inquiry to examine systems in the Department of Education relevant to minimising the risk of child sexual abuse within Tasmanian government schools. The report of the Inquiry was submitted in June 2021. For the final report, refer to Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education’s Responses to Child Sexual Abuse* (Final Report, 7 June 2021) 1.

3 Peter Gutwein, Premier of Tasmania, ‘Premier’s Statement – Commission of Inquiry’ (Media Release, 23 November 2020) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>.

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7 Peter Gutwein, ‘Premier’s Statement – Commission of Inquiry’ (Media Release, 23 November 2020) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>.

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16 *Commissions of Inquiry Act 1995* s 19(2A).

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31 Donald Palmer and Valerie Feldman, 'Toward a More Comprehensive Analysis of the Role of Organizational Culture in Child Sexual Abuse in Institutional Contexts' (2017) 74 *Child Abuse and Neglect* 23, 25.

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85 Submission 084 Integrity Commission Tasmania, 2.

Findings

86 The name 'Henry' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

87 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

88 The name 'Ray' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

89 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

90 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

91 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

92 The names 'Ira', 'Lester' and 'Stan' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

93 In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

94 The name 'Dr Tim' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 27 June 2022.

Glossary

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100 Refer to Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 1995*, 15 March 2021, 5 (refer to Appendix A); *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 1, 19. For the purposes of this Commission of Inquiry, we have replaced the word 'fondling' with the trauma-informed term 'touching'.

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103 Department of Premier and Cabinet, ‘9.2 Heads of Tasmanian Government agencies’, *Tasmanian Government Communications* (Web Page) <https://www.communications.tas.gov.au/policy/roles_and_responsibilities/heads_of_tasmanian_government_agencies#:~:text=The%20head%20of%20agency%20leads,champions%20the%20agency’s%20internal%20communications>.

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108 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 1, 2–13. *State Service Act 2000* pt 2.

109 *State Service Act 2000* s 9.

110 *State Service Act 2000* s 9.

111 Cathy Kezelman and Pam Stavropoulos, *Organisational Guidelines for Trauma Informed Service Delivery* (Blue Knot Foundation, 2020).

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