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

WITNESS STATEMENT OF KATHRYN LOUISE FORDYCE

I, Kathryn Louise Fordyce, [redacted], in the State of Tasmania, Chief Executive Officer of North and North West Sexual Assault Support Service Incorporated, known as Laurel House, (03) 6431 9711, do solemnly and sincerely declare that:

1. I am authorised by Laurel House to make this statement on its behalf. Where I offer statements or opinions in relation to children with disabilities, I do so based on my previous experience in the disability sector, not on behalf of Laurel House.

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

3. Laurel House made a submission to this Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings in July 2021. I refer to and adopt that submission. Attached to this declaration and marked **KF-1** is a copy of the Laurel House submission dated July 2021 bearing document identification number **SUBM.0001.0083.0001**.

BACKGROUND AND QUALIFICATIONS

4. I have the following qualifications:

   (a) Bachelor of Speech Pathology (Honours) from the University of Queensland;

   (b) Graduate Certificate in Health Services Management from Charles Darwin University; and

   (c) Diploma of Early Childhood Education and Care from TasTAFE.

5. I am currently:

   (a) a Deputy Chair of Playgroup Australia and a non-executive director of Playgroup Tasmania;

   (b) the Tasmanian Branch Deputy Chair of Speech Pathology Australia;

   (c) the treasurer of Providers of Sexual Assault Care (PSAC);

(d) a board member of National Association of Services Against Sexual Violence (NASASV);

and

(e) the Chief Executive Officer (**CEO**) of Laurel House.

6. I commenced my role as CEO of Laurel House in May 2021. In this role, I am responsible for:

(a) Raising awareness amongst the community about sexual violence and Laurel House;

(b) Representing Laurel House with stakeholders and the community, and advocate for the organisation and victim-survivors;

(c) Driving the strategic outcomes of the organisation;

(d) Leading the day-to-day operations of Laurel House, and provide oversight over all financial and compliance matters;

(e) Delivering high quality project and grant outcomes.

7. My previous roles include:

(a) Between October 2016 and May 2021, I was engaged as General Manager at St Giles Society, based in the north-west of Tasmania and delivering specialist early intervention and diagnostic services state-wide;

(b) Between May 2011 and October 2016, I was engaged as Autism Centre Manager at Burnie City Council, where services were delivered across the north-west of Tasmania;

(c) Between July 2008 and May 2011, I was engaged in various roles with Positive Partnerships, a federally funded national training program lead by Autism Spectrum Australia, based from Brisbane, Queensland;

(d) Between July 2002 and December 2009, I was engaged in various roles with Autism Queensland, based in Brisbane.

8. Attached to this declaration and marked **KF-2** is a copy of my curriculum vitae.

LAUREL HOUSE

9. Laurel House is a not-for-profit, community-based sexual assault support service operating in the north and north-west of Tasmania. It was established in 1989 to provide trauma counselling and support for victim-survivors of sexual harm and to provide education, training and advocacy in northern Tasmania. Laurel House took over the operations North West Centre Against Sexual Assault Care Inc (NWCASA) in July 2012.

10. Laurel House provides a range of confidential Tasmanian Government-funded services that are free to victim-survivors throughout north and north-west Tasmania.

11. Laurel House also holds an Australian Government National Disability Insurance Scheme (NDIS) Information Linkages and Capacity Building (ILC) Grant focused on improving workforce capacity to respond to sexual violence in people with disability.

12. Laurel House is committed to the belief that everyone has the right to live free from the violence of sexual assault. It believes that education, primary prevention strategies and law reform are key to eradicating sexual violence from society. Laurel House's vision for 2022 is to be known throughout Tasmania as a leader in the field of sexual abuse trauma counselling and support, education and training, and as a dedicated advocate for policy reform. Laurel House aims to provide an inclusive, holistic service that addresses sexual inequalities and abuses by advocating for individuals and communities for change.

13. Laurel House provides support and counselling to all individuals that have been affected by sexual harm. This includes victim-survivors of recent or historical child sexual abuse, other victim-survivors of recent or historical sexual assault, and their family members and other people who have vicariously been affected by sexual harm (e.g., service providers who have received a disclosure). Where there has been a recent sexual assault, Laurel House provides victim-survivors with support to understand their choices when interacting with the police and when considering whether they will consent to a forensic medical examination, and provides immediate crisis counselling and support to the victim-survivor and their families.

14. Laurel House has an operating budget of approximately $2.3 million for the 2021-22 financial year. The bulk of our funding comes from the Department of Communities for the delivery of the Tasmanian Sexual Assault Service in the north and north-west regions of Tasmania. We currently hold a three-year agreement from 1 July 2021 to 30 June 2024. In 2021-22 financial year, Laurel House received one-off COVID Response funds ($124,000 ex GST), and additional one-off funds ($250,000 ex GST). On the 14 April 2022, we received confirmation that one-off funds would also be provided into the 2022-23 financial year. These additional one-off funds have allowed us to employ additional counsellors in the north and north west.

15. Laurel House's Tasmanian Government funding also includes the provision of preventative and awareness education and training to communities and other professionals to reduce and better respond to instances of sexual violence. Currently, Laurel House's primary prevention work is more limited than we would like it to because demand for counselling services is high. While we would like to place greater emphasis on our primary prevention and community education work, doing so would lead to increased waiting times for counselling and support for those who have experienced sexual harm.

16. In March 2020, Laurel House received a two-year grant from the National Disability Insurance Scheme (**NDIS**). The purpose of the grant is to develop and deliver training and resources to educate the health and disability workforce about the prevalence of sexual assault and child sexual abuse in people with disabilities, and to upskill the workforce to understand their responsibilities and to become better responders. This program, known as the 'Disability Workforce Support Project', project aims to give members of the disability and health workforce an understanding of how to respond in a trauma-informed way to suspected or actual sexual abuse against people with disabilities.

Counselling services

17. Laurel House offers face-to-face, online and phone counselling to adults, young people and children, as well as their families and supporters. Laurel House provides these services from its offices in Launceston, Burnie and Devonport and through outreach in rural locations.

18. The funding Laurel House receives from the Tasmanian Government is applied to cover the costs of:

(a) staffing an **1800-number telephone line** that operates during business hours. This line is a central telephone line that can be called by a victim-survivor to report an incidence of sexual abuse or to seek information or support. This 1800 number is shared state-wide with the southern based, Sexual Assault Support Service (SASS), and is answered by a call-back message service. The details of the caller are recorded and provided to the appropriate service depending on the caller's location. The service immediately (typically within 15 minutes) will call the person and attend to their requirements.

(b) staffing an **after-hours 1800-number telephone line**, which is answered 24 hours a day seven days a week. This phone line received approximately 170 calls last year and can be contacted in events of emergency, such as a recent sexual assault, or where a victim-survivor may be experiencing severe trauma symptoms;

(c) providing **support for recent sexual assault**, which includes assistance to understand their choices in relation to reporting to police and accessing forensic medical examinations, and providing advice, information and referrals for the next steps;

(d) providing **specialist counselling services**, for victim-survivors and others affected by sexual harm. Laurel House employs tertiary-qualified counsellors with qualifications in social work, psychology, or counselling. We would consider employing mental-health accredited occupational therapists but to date have not employed anyone with this qualification and experience. The majority of Laurel House's counsellors are social workers, likely due to local training opportunities in the north and north-west Tasmania. Within the national context of allied health shortages, psychologists are in particular short supply in north and north-west Tasmania. We seek to recruit counsellors that have at least 3 years post-qualification experience, and provide considerable additional training and regular internal and external supervision. Laurel House counsellors utilise therapeutic models and programs that are informed by trauma

research and practice that identify sexual violence, of all types, as a gendered crime. Laurel House counsellors provide person-centred supports that draw on the concept of intersectionality. The choice of therapeutic models and practices is determined with consideration to the level of complexity of the trauma, the client's needs, preferences and goals, and the counsellor's training and practice experiences. Counsellors may use a range of different counselling methods and therapeutic techniques that are adapted to suit the individual needs of the client including psychoeducation about trauma and post-traumatic stress reactions, teaching emotional regulation skills, supporting the establishment and maintenance of adaptive routines and behaviours, fostering support networks, and a range of different therapeutic approaches including, but not limited to, trauma-focused cognitive behaviour therapy, acceptance and commitment therapy, narrative therapy, eye movement desensitisation and reprocessing (EMDR) therapy.

19. The vast majority (80% to 85%) of our clients are victim-survivors of sexual harm, with the next largest group being family members of victim-survivors (approximately 10%) and the remaining clients are other people like service providers or people who have witnessed sexual harm. Our clients are self-referred (25%), referred by family members/friends (20%), by police (10%) or by service providers (44%). The referred client is then contacted within 24 to 48 hours for an intake and initial assessment to gain an overview of the client's presenting issues, risks to client safety and the safety of any dependent children and to determine what service options will be available both within Laurel House and through referral to other services. The referral is prioritised, depending on how severe the impact of the sexual harm has been on them. There are three levels of priority: high priority, medium priority and low priority.

20. Children are always given a high priority, and take precedence over adults who are also categorised as high priority. Children are then allocated depending on risks to their safety. As an example, if two children were to experience sexual abuse, but only one of those children presented with suicidal ideation, that child would be prioritised.

21. Between July 2021 to April 2022, we received data on the perpetrator for approximately 53% of the 410 adult and 245 child clients who received counselling during this period, while the remaining 47% did not provide details of the perpetrator's relationship. Of those who provided details of the perpetrator:

    (a) two adults reported child sexual abuse by clergy;

    (b) two children and one adult reported child sexual abuse in out of home care;

    (c) three adults reported child sexual abuse by a person in a position of authority;

    (d) three adults reported child sexual abuse by a teacher.

    (e) five children reported child sexual abuse and one child reported sexual harassment from an unrelated child.

22. For the same time frame, we received data on the location of primary incident of sexual harm for approximately 26% of the 410 adult and 245 child client who received counselling during this period, while 74% did not provide details of the location of the incident of sexual harm. Of those who provided details:

    (a) one adult in which sexual harm occurred at a church;

    (b) one child and four adults in which the sexual harm occurred at a hospital;

    (c) seven children and two adults in which the sexual harm occurred at a school;

    It should be noted that report used to obtain this data does not reliably allow us to determine if the sexual harm occurred to adults while they were children or while they were adults.

23. As at 31 March 2022, we had 44 people on our waitlist for counselling — 30 are in the north-west, and 14 are in the north. In the north-west, the average wait time for high priority referrals is 31 days, with a current maximum wait of 66 days. For the north, the average wait for high priority referrals is 21 days, with a maximum wait of 60 days. These wait times include children and adults, and typically children would be seen much more quickly than adults. In

Tasmania, our waiting times for counselling are better than in some other parts of the country where in some locations waiting times can be 6 to 12 months or there may be little to no access to long-term therapeutic counselling. Additionally, and our waiting times are currently much better than they have been at various other points over the past few years, but it is important to recognise that any time waiting for counselling is a long time to wait for a victim-survivor who has experienced sexual harm.

24. All victim-survivors and others affected by sexual harm respond differently, there is a need to respond individually to each client and offer a tailored response to meet their needs. Some victim-survivors may need significantly more time and resources than others to achieve a certain level of therapeutic response. Some victim-survivors, regardless of age, need regular counselling over an extended period, whereas others may need a shorter period of counselling or blocks of counselling where they are encouraged to return if their trauma is triggered following discharge from services. It is typical that the family members of children who have experienced child sexual abuse would receive support to both meet the needs of the child, but also separately to address the impact of the sexual harm on their own wellbeing.

25. While the delivery of therapeutic support and the specific needs of the victim-survivors differs between individuals, the desired outcome of those supports tends to be somewhat similar. Most victim-survivors want support to increase their understanding of their options including in relation to seeking justice, to increase their sense of safety, to reduce trauma-related symptoms (e.g., anxiety, flashbacks/intrusive memories, poor sleep), to build their coping strategies and ultimately to reduce the impact of the sexual assault/abuse on their day-to-day lives and relationships.

26. Our services are trauma-specialist and trauma informed which means we work to ensure that our supports assist in recovery from the trauma of sexual harm, and actively avoid retraumatising victim-survivors. This means that we do not seek to understand the specific who, what, when, where and why of the incidence or incidents of sexual harm experienced by a victim-survivor. Quite often staff at Laurel House do not know the identity of a perpetrator or the intricacies of the sexual abuse. Expecting victim-survivors to relive their

experience is not necessary for our counsellors to support victim-survivor to reduce the impacts of their trauma and to live a meaningful life.

27. For adults who experienced childhood sexual abuse, we find that our approach to supporting victim-survivors is similar if they have experienced the abuse within a family setting or through an institution. While there are nuances in the response to child sexual abuse, victim-survivors of child sexual abuse from family members or other people in positions of authority who should have been focused on preventing harm to the child, can have significant impacts on interpersonal relationships. The needs of victim-survivors can vary depending on the response they received to their initial disclosure and if family members, friends and other important people have believed and supported the victim-survivor. We also see some differences in how male victim-survivors present for support with survivors likely due to how society conditions men and boys to act and respond. Victim-survivors of institutional child sexual abuse can be less receptive to receiving treatment from any institution, due to the breakdown of trust that follows institutional abuse.

General support services

28. Laurel House also runs a 24-hour support service in relation to the forensic, medical and legal processes associated with sexual harm (including child sexual abuse). These support services include:

    (a) speaking with victim-survivors by telephone or in person at the hospital or police station in order to:

        (i) provide information, support and assistance;

        (ii) ensure the victim-survivor's rights are maintained;

        (iii) coordinate the victim-survivor's choices.

    (b) supporting clients during forensic medical examinations. This involves:

        (i) coordinating with the on-call forensic examiner to determine a time for the examination to occur, and arranging the preparation of hospital rooms for a client's arrival;

(ii) explaining the client how they can best preserve evidence on their body and clothes prior to the examination;

(iii) meeting the client at the hospital and explaining the process of the forensic medical examination, reporting processes with the police and any other medico-legal processes to ensure they are aware of their choices and to ensure informed decision making;

(iv) explaining the services that are available following the forensic medical examination;

(v) being close by (in an adjoining room waiting with any support person), or remaining with the victim-survivor while the medical personnel conduct the forensic medical examination

(vi) in the event the victim-survivor does not elect to proceed with the examination, providing them with information, including an option to come back and obtain support.

(c) acting as a support person for clients before, during and after police interviews;

(d) assisting clients in preparing for court and attending court as a support person.

29. Existing clients often want a support person from Laurel House to support them through these processes, due to their developed, long-standing and trusted relationship. Additionally, clients value that our sole role is to support them to understand and enact their choices. We do not have any other motive other than to support them in their recovery which may or may not include seeking justice through criminal or civil jurisdictions.

Redress support services

30. Laurel House is not a National Redress Scheme Support Service, but we do advise victim-survivors of their options to access this scheme and make referrals to local or national Redress Scheme Support Services if they have experienced institutional child sexual abuse. Our counsellors would also provide information about National Redress Scheme Legal Service, knowmore. Often our clients will spend time accessing counselling and other support from

Laurel House before taking the step to contact a National Redress Scheme Support Service or to pursue civil litigation.

31. Both the National Redress Scheme and civil litigation are highly stressful for victim-survivors: there are deadlines that must be met; limited time within which to make informed decisions; pressure to accept offers and assign a monetary value to the trauma of child sexual abuse; all of which can create immense stress for victim-survivors. Additionally, both require victim-survivors to retell the details of their experience which can cause high levels of distress and retraumatise victim-survivors.

32. Our counsellors report that clients find the National Redress Scheme slightly less stressful than litigation, which is likely due to the additional supports offered through the Redress Scheme Support Services and Legal Services. Although clients might receive less money compared to a successfully litigated claim, a Redress Scheme claim avoids the process of cross-examination. Our counsellors have seen victim-survivors withdraw from civil proceedings because they are worried about people belittling their experience and engaging in character assassinations.

33. I have also received feedback from clients via our counsellors that not all lawyers who work in civil litigation are trauma informed. They therefore do not have the necessary skills to navigate a claim appropriately with their client, including when gathering factual evidence.

34. Our counsellors report that victim-survivors do not always fully understand the difference between the processes that are available to them to seek compensation. The whole process causes confusion. For an individual who is already on high alert, the process can trigger intense trauma responses and cause them to withdraw.

35. If a client of Laurel House pursues civil litigation, the litigation often becomes the focus of that client's therapy. Our therapeutic efforts turn to focus on the sequelae that arise as a result of the civil litigation. The therapy shifts to how the client can keep themselves psychologically and physically safe during the civil litigation process.

TRAUMA INFORMED RESPONSES

36. Trauma-informed responses require us to create environments that are welcoming, reassuring and respect the impact that sexual harm may have on a victim-survivor. Trauma-informed responses to child sexual abuse need to promote that the child is believed and that their experience is validated.

37. In my experience, many adults — and thus those who receive initial disclosures, and those who investigate and respond to reports of child sexual abuse — generally perceive children as inherently unreliable and bad witnesses. When children report child sexual abuse, they are not always believed, or there is a sense of needing to check with other adults to check the veracity of the child's report. This impacts on the child's willingness to share more information that may be necessary to act on the child's report.

38. Trauma informed approaches to policing can make a huge difference to a victim-survivor's experience; they can provide a pathway to healing. As an example, I acted as a secondary support person to a victim-survivor when giving a statement to police. The police officer approached the interview in a trauma-informed way. The police officer contacted the victim-survivor and the person who the victim-survivor had disclosed to (a trusted service provider) in advance to arrange for the interview to be held at Laurel House, because it was a familiar environment. When the officer arrived, they were not in uniform; only a lanyard identified them as a police officer. The officer intentionally rearranged the room so that she was not sitting directly across from the victim-survivor. The officer acted in a personable way, for example, getting a pencil case out on the table, and made sure to humanise the situation. The officer explained the entire process, including why the interview needed to be recorded. The officer made clear that the recording was to empower the victim-survivor and to make sure that their words were protected. The officer made sure that choices were offered to the victim-survivor throughout the whole process. For example, the officer asked whether it was okay to sit in a certain place. When the victim-survivor needed to show the officer something on their phone, the officer asked for permission to hold the phone and to scroll through the images. When the officer could see that the victim-survivor was distracted, the officer reassured the victim-survivor of the process and the reasons for the interview. There were several breaks, and when the officer saw that the victim-survivor was getting anxious, the officer would break up the conversation with

light-hearted topics known to be of interest to the victim-survivor. At the end of the interview, the officer was very clear about the next steps and that it would take some time to progress the investigation.

39. The police officer in the above example made very clear to me that even if the officer was unable to proceed with charges for a recent sexual assault and historical child sexual abuse, the officer recognised the important role that police can play in giving the victim-survivor closure just by acknowledging that they have been hurt, that they were not to blame, and that the perpetrator was at fault, and that they were believed.

40. Unfortunately, not all experiences with police are as positive. Some police officers seem less willing to engage with victim-survivors unless there is a likelihood of the situation leading to a prosecution. We have some police wanting details documented on referral form and others telling victim-survivors that there is no point talking to the police unless they want to proceed with a prosecution.

41. Many police officers can take a prosecutorial, rather than trauma-informed, approach to reports of sexual assault including historic child sexual abuse. I believe this is often based on the notion that it is not worth investing time into a complaint unless there is a prospect of conviction. This can be really demeaning and dismissive for a victim-survivor. A trauma-informed response by police investigators would provide a victim-survivor with their right to be heard and reassure the victim-survivor that sexual abuse/assault is not their fault. Police officers should not be solely drive by the prospect of prosecution. The investigation should be an end in itself.

42. Trauma-informed responses do not invalidate a victim-survivor's report of sexual assault. I once had a conversation with a police officer who complained that the stories of victim-survivors sometimes contained details did not make any sense or were simply not possible. A trauma-informed response to inconsistent testimony would recognise what trauma does to a victim-survivors memory and recollection of events, and to the way information is communicated. This may mean that more time is needed to understand the person's communication needs and preferences, to provide time to share their experiences, and to use a different ways of communicating and documenting that allows the person to confirm that what has been heard is what they meant

– the witness intermediary program can assist here assuming they are engaged by police for those whose trauma presentation may be affecting their ability to communicate the details of their assault or abuse. A non-trauma informed response to inconsistent testimony and other issues that may arise as a result of issues with memory can be just as destructive as the trauma itself.

43. Increasing awareness of trauma-informed responses and care extends far beyond the police too. Given the prevalence of sexual violence in our community, especially the level of sexual violence in marginalised communities such as people with disabilities, those from the LGBTQIA+ community, Aboriginal people and those from culturally and linguistically diverse backgrounds, there is a need for all mainstream health, education and other government and community services to be more trauma-informed and responsive to the needs of victim-survivors of sexual harm.

44. Laurel House is supportive of the introduction of multi-disciplinary centres that provide opportunities for collaborative and integrated responses to victim-survivors in one location. Laurel House has benefited and seen the benefits of developing positive working relationships with police and other services in terms of modelling and championing the principles and practices of trauma informed care. Laurel House notes that multi-disciplinary centres, even if police-led, should not be visibly obvious as police facilities, and police should be inconspicuous. The space should be welcoming and engaging for children and adults regardless of gender, sexuality, disability, cultural background and experience, and the environment, processes and practices should be co-designed with victim-survivors and sexual assault service providers. Attention should also be given to cohorts of victim-survivors who do not want to engage with Police or Government – the introduction of multi-disciplinary centres should not prevent access to counselling services for those adult victim-survivors who do not wish to report their experience of sexual harm to police, and victim-survivors need to continue to have choice in when and how they engage with police and other government services.

PRIMARY PREVENTION

45. Laurel House offers community, workforce and school-based education, professional training and debriefing services. We currently run the following programs:

    (a) 'Consent – Sex & Respect' which is a six-session program that covers important topics like healthy and unhealthy relationships, consent and the law, relationship violence and online safety. This program is offered to high schools and clubs and groups with teenage members.

    (b) 'Consent – Respect & the Law – Essentials for Adults' which is a joint initiative with the Women's Legal Service Tasmania Inc to provide teachers, parents, carers, coaches and adults in the school community with information on how they can create environments that prevent violence and support young people to understand healthy relationships, consent and the drivers of gender based violence, and how they can respond to disclosures of violence or concerns they have about unhealthy relationships.

    (c) One-off training sessions on consent, respectful relationships and how to party safe for school students.

    (d) Customised training for service providers and schools including on the prevalence and impact of sexual assault of people with disability, responding to disclosures, supporting decision making for people with disabilities, self-care and vicarious trauma, and other related topics.

46. All Laurel House's training and primary prevention activities have been developed in house, and with collaborators such as Women's Legal Service Tasmania. We also seek the advice of steering groups that include people with lived experience of sexual harm, and actively seek feedback from the target audience (e.g., young people, disability service providers, GPs) to ensure the content is suitable and to refine the programs based on their feedback

47. Laurel House is currently working with White Ribbon and Women's Legal Service Tasmania to explore opportunities to support parents of young children to better understand how they can promote gender equality, be alert to grooming and promote the agency and bodily autonomy of young children. While there are a range of programs such as Bravehearts, All Come Out to

Play (Playgroup Victoria and Drummond Street Services) and Talk Early by the Daniel Morcombe Foundation, there is no state-wide consistency in early childhood support services that would ensure educators, playgroup facilitators, child health nurses, and other professionals are equipped to support parents and young children (including those with disabilities).

48. Similarly, education opportunities addressing the gendered drivers of sexual violence, grooming, bodily autonomy, consent and respectful relationships for primary and high school students, and their parents/carers is not uniformly available across the state with some schools taking highly proactive approaches and others failing to appropriately address the needs of the school community.

49. Laurel House is committed to the National Principles for Child Safe Organisations, and through our work with other organisations and steering groups we champion the need for organisations to actively seek the voices of children, to promote children's rights and supporting children to know what they can do if those rights are infringed. We are also working to continuously improve our own processes and practices in relation to the National Principles and are looking to introduce a youth victim-survivor reference group to allow children and young people to contribute to decision-making in the organisation.

50. There is a lot more work needed in organisations of all types including schools, health and disability services to ensure that we address the drivers of sexual violence, to teach children about respectful relationships and how to speak up when they feel unsafe or when something has happened to them. Unfortunately, there are social norms that mean we condition children, especially those with disabilities and health conditions, to be compliant and submissive. For example, it is common that children are expected to kiss or cuddle extended family members even when they don't want to. Things are even more complicated for a child with a disability or a health condition who has been poked and prodded their whole life, and had their personal space invaded many times for legitimate medical or care reasons. All too often adults ignore a child's attempts to maintain their bodily autonomy, and then those same adults are surprised when children are abused and do not report it. We need to create conditions where children have ownership of their own bodies and we need to ensure that children of all ages and abilities, and their

parents/carers have access to developmentally appropriate respectful relationship education.

51. Laurel House has welcomed the recent calls for increased respectful relationship and consent education in schools, and in the introduction of new content in National Curriculum about these topics. Laurel House supports the position of the National Association of Services Against Sexual Violence (NASASV) for respectful relationship educators in all schools. We are keen to see a whole school approach that is focused on ensuring that all staff in a school understand their role in promoting gender inequality, modelling and talking about respectful relationships, being active bystanders and intervening when they see behaviour that creates an environment that is permissive of violence, and in responding to disclosures of sexual and family violence. Laurel House is motivated to work with school leaders and teachers to build their capacity to create environments where there are open discussions about preventing sexual violence and promoting equality and respectful relationships.

52. A whole school approach to preventing and responding to violence, would include a clear plan that systematically outline how schools respond to concerns about the conduct of members of the school community events or to disclosures of abuse. By developing these plans schools will be ready to respond immediately and know who is responsible for what in the event of concerns about the abuse of children or where a child is displaying harmful sexual behaviour. This would allow a coordinated and trauma-informed response that prevents further retraumatisation of child victims, and minimises the risk of vicarious trauma of the school community, and ensures that relevant internal (e.g., school social workers) and external resources (e.g., Laurel House) are coordinated in the response. The development of the plan will allow for the identification of preventative strategies and development needs of school staff. For example, training on responding in a trauma-informed way to a disclosure, ensuring all staff understand their obligations to report their concerns, and developing relationships with local specialist services.

53. Smaller schools in smaller communities, in particular, will need to be adequately resourced to promote the safety of children. The risk profile and level of support in these schools and communities are different, and there can

be less visibility in these locations due to reduced staffing and visiting services, like allied health professionals.

54. If Laurel House had additional resources, we could engage in more preventative support, rather than being a predominantly reactive service. We could focus additional efforts towards preventing the occurrence of child sexual abuse by educating people working in and interacting with institutions where there are high incidences of abuse. We would like to be more visible in schools and the community so we can supplement formal training opportunities with incidental conversations with people who work with children to help them understand the critical role they play in preventing, identifying, responding to and reporting sexual abuse, and other forms of violence. While we receive many phone calls from teachers and service providers for secondary consultations where they are seeking advice and support, I suspect there are many more teachers and service providers who are not aware of the services Laurel House provides and the support we can offer via our Tasmanian Government funded program, including the advice that we can provide in relation to their obligations, how they can best support children and families, determining the appropriate referral pathways, and in ensuring their own well-being while they navigate supporting a child and family. The support offered by Laurel House complements the support offered by the Strong Families Safe Kids Advice and Referral Line (ARL). Some community members can feel more comfortable to connect initially with a non-government organisation to seek information and to clarify that there is a need for action, while others will follow up with Laurel House after their interactions with the ARL to gather more specific information and advice about the next steps in seeking support for a victim-survivor or a child who exhibits harmful sexual behaviour.

HARMFUL SEXUAL BEHAVIOUR

55. As a specialist sexual violence service, Laurel House provides services to children and young people who exhibit harmful sexual behaviour. In many, but not all cases, these children are victims of sexual harm.

56. Laurel House is actively focused on building the capacity of our service to deliver services to children with harmful sexual behaviours consistent with the recommendations of the Royal Commission into Institutional Responses to

Child Sexual Abuse. Currently, there is not a consistent model of service delivery offered by all members of the Laurel House team, and we are working to build a more consistent service model. On receipt of a referral for a child exhibiting harmful sexual behaviour, or where information is obtained about harmful sexual behaviour during counselling, the Laurel House counsellor would conduct an assessment of a child and young person and would develop a plan to support the child and their family drawing on evidence-based practices. However, it is however our intention to shift towards the Assessment Intervention Moving On (AIM) assessment framework and will have all clinical staff trained in the AIM and more experienced staff in the AIM2 by the end of 2022

57. AIM is a holistic framework for assessing children's needs, specific risks and identified strengths in the child and their family. It provides a comprehensive and interlinking suite of models, frameworks and practice guidance method is an evidence-based process. Sexual Assault Support Service (**SASS**) currently use the AIM in the delivery of their harmful sexual behaviour program, and I think that consistency across the entire state would assist in supporting collaboration, referrals and developing a shared understanding between services.

58. SASS has recently received funding from the Tasmanian Government to provide a specialist harmful sexual behaviour program across Tasmania which includes the provision of support for children over the age of 12 who display harmful sexual behaviours. This program is new and there remains some lack of clarity regarding referral pathways and there are opportunities to strengthen collaboration. Prior to the introduction of this funding, there was considerable inconsistency in support for older children exhibiting harmful sexual behaviour. Some school-based social workers and psychologists would do their best to address the needs of children and teachers, while in other instances support would be sought from NDIS funded behaviour support practitioners, privately funded psychologists, Child and Youth Mental Health Services or other medical or allied health professionals but the pathway to support was not clear nor consistent.

59. Currently, we would provide support for all children under 12 who are exhibiting problematic or harmful sexual behaviour but would refer to SASS when the

harmful sexual behaviour is severe because they have funding and a specialist team in place that is better able to provide services in those circumstances. When we have older children that are exhibiting low to mid-range harmful sexual behaviours, the practitioners at Laurel House make a judgment call on whether they have the skills to continue to deliver the support to the child, rather than to close off the therapeutic relationship at 12 and refer them to SASS.

60. While it is positive that dedicated funding is now being provided supporting children exhibiting harmful sexual behaviour, it would be valuable for Laurel House to also have this funding so that support for harmful sexual behaviour can be more effectively integrated with Laurel House's other supports, to allow for continuity of holistic-trauma informed care at one location for clients and families, and to allow for a local response with local workers who have established relationships with schools and other service providers.

61. In the meantime, there is room for improving the interactions between Laurel House and SASS in relation to the delivery of services to children and young people with harmful sexual behaviour, especially where Laurel House already has an existing therapeutic relationship with a child or family. This issue becomes even more important if the child engaging in harmful sexual behaviour is also a victim-survivor of child sexual abuse. It is reasonably common to find that children who are exhibiting harmful sexual behaviours have also been sexually abused themselves so there is a need to clarify and refine the processes for cross-referral and service interfaces including where a child completes or ages out of the SASS program and may need ongoing consent support in relation to child sexual abuse.

62. When responding to harmful sexual behaviour it is important that the child and their family are not shamed or ostracised by the incident/s and children are not labelled as perpetrators or offenders, because this can isolate the child and family further and prevent them from accessing proper treatment and support. Treatment should be non-punitive and focused on behaviour change, with a focus on ensuring the safety of other children who may have contact with the child with harmful sexual behaviour. Parents and carers need to be actively engaged in the treatment process especially where there are siblings or other children in the household. If a child and their parents are approached in a

sensitive and non-stigmatising way, while making it clear to the child which behaviours are inappropriate and need to change, as it gives the best chance of the child receiving appropriate and effective treatment.

63. If parents are shamed, they can fail to appropriately involve themselves in the treatment process, which is often necessary in order to deliver a holistic treatment plan. So, it is important that teachers and other service providers are aware of how to appropriately respond to and discuss harmful sexual behaviour, to bring everyone to the table and in a way that works in the best interest of the child and their treatment.

64. The same issue is faced by workers in out of home care settings. They can feel a sense of shame and judgment due to the fact that harmful sexual behaviour is occurring under their care. Thus, it is important that the same approach is taken towards addressing harmful sexual behaviour exhibited by children in out-of-home care. The fear of judgement can prevent carers from disclosing instances of harmful sexual behaviour, which in turn allows the behaviour to continue and can place the child and other children at risk.

65. In my time at Laurel House, there have been multiple referrals of out of home care children displaying harmful sexual behaviours towards peers. We also have a number of adult victim-survivors who were in out of home care as children who, on reflection, acknowledge that there was sexual violence perpetrated by carers and harmful sexual violence perpetrated by peers. We have a number of ex-Ashley Youth Detention Centre residents on our case load, both active clients and previous clients.

66. Last year we ran a program at Ashley Youth Detention Centre in response to a group of children demonstrating a range of inappropriate and problematic harmful sexual behaviours, such as mooning, making lewd comments. The program focused on exploring concepts of consent and respectful relationships, and provided the young people with the opportunity to discuss these topics in a safe and non-stigmatising environment. The feedback we received was that post program there was a noticeable and significant improvement in the behaviour of children in the care of Ashley Youth Detention Centre.

67. With respect to harmful sexual behaviours in schools, both research and our experience has found that most teachers feel totally ill-equipped to respond to harmful sexual behaviour. Commonly, teachers do not know what developmentally normal sexual behaviour in children looks like. Sometimes teachers will overreact to completely normal behaviour or, alternatively, dismiss things that would be considered inappropriate, problematic or abusive. There is generally a limited understanding of the spectrum of sexual behaviour and the point at which intervention is required.

68. One issue that needs to be addressed is the burden placed on teachers, school social workers, and psychologists to implement strategies to address harmful sexual behaviours in schools. The role of teachers in schools are complex and multi-faceted, and school social workers and psychologists are often at capacity with child safety matters, mental health and other general safety planning and critical incident briefings; it is not realistic to expect them to have intricate trauma-informed knowledge of how to address harmful sexual behaviours and then educate staff on those matters.

69. There is a need for a more coordinated approach to be occurring locally and state-wide between Laurel House, SASS, the Department of Education and other health, disability, youth and justice services. There is a working group within the Department of Education that is focused on Harmful Sexual Behaviour which will be valuable in strengthening interagency practice, and in considering how specialist organisations like Laurel House can support the work of schools and other services to adopt a public health approach where there focus on primary prevention, early intervention (secondary prevention) and tertiary intervention.

70. A public health approach for harmful sexual behaviour would involve upskilling all (or a significant number of) staff in identifying and responding to harmful sexual behaviour and build their capacity to support the understanding of children and parents. This would require educating staff on normal sexual development, how to identify early warning signs of harmful sexual behaviours, how to manage inappropriate sexual behaviours and prevent an escalation of harm, to understand the pathways to additional support are referred for assessment and intervention and their reporting and information sharing responsibilities. Additionally, school staff and other service providers need to

understand what will happen when an incident occurs including the development of a safety plan for the child and any victims, a comprehensive assessment (which identifies the likely reasons behind behaviours of concern, explores why certain harmful sexual behaviour may happen, the triggers of behaviour and potential trauma behind harmful sexual behaviour) and the development of a behaviour plan which sets out the expectations for behaviour and how the child will be supported.

71. We hear from many teachers and other service providers who feel ill-equipped in how to prevent and manage inappropriate and harmful sexual behaviour, and they note that education and upskilling is often only provided *after* a 'high-level' instance of harmful sexual behaviour, as a reactive response rather than as a proactive preventative measure.

CHILDREN WITH DISABILITIES

72. Sexual abuse occurs of children with disabilities occurs at a higher rate to sexual abuse of children without disabilities. Ultimately, like all sexual assault, the drivers of this violence is intersecting expressions of gender inequality and other forms of oppression, in the case of children with disability, ableism. Perpetrators of sexual violence use patterns of violence to exert power over their victims and will often choose victims based on their perceptions of their vulnerabilities.

73. Unfortunately, due to societal attitudes towards people with disabilities, children with disabilities are often perceived as even less reliable and credible sources of information than the general population of children, who are already seen as unreliable. So, reports of child sexual abuse are not approached seriously and with the requisite level of concern.

74. Children with disabilities are not being included, to the same extent, in education and conversations about safe and respectful relationships, and about consent. Ableism plays a role in creating an environment where children with disabilities are subject to sexual violence, and other forms of violence. For example, negative stereotypes about people with disabilities including that they are child-like, sexless, genderless or hypersexual and lead to children with disabilities not being included in mainstream respectful relationship education or sex education. Rather than provide children with disabilities different

pathways to learn about safe and healthy relationships, many are simply deprived of the mainstream education processes without being offered any alternative option. This is notwithstanding the fact that it is known that children with disabilities are more likely to be subjected to child sexual abuse.

75. As an example, I have had several parents of children with disabilities report to me that their children's schools had engaged a leading child protection organisation that works to prevent child sexual abuse to provide safe relationships education to its students. However, the schools had excluded some children with disabilities from the session for fear that those children may have been upset by the sessions or that they would be disruptive to the other children during the session. This resulted in these children missing vital education that aims to prevent the perpetration of child sexual abuse.

76. Additionally, children with disabilities face additional barriers to reporting sexual abuse. One reason for this is that children with disabilities are often deprived of the necessary skills to keep themselves safe including teaching and supporting them to communicate their bodily autonomy. Children with communication delays are at high risk because they are unable to disclose when something is wrong using verbal means, and those with complex communication needs are reliant on intentional inclusion of ways to communicate about their bodies or experiences of unwanted touch or other behaviours. I am aware of a number of circumstances were parents, teachers or other carers have asked speech pathologists to not include or to remove words like 'penis', 'vagina' or other important words needed to describe an incidence of child sexual abuse from aided communication systems.

77. It is particularly important that children with disabilities are given the skills to communicate instances where they do not feel safe, are sick, have been injured or have experienced child sexual abuse. While most child sexual abuse will occur from a known person and in many instances by family members, all children but especially those with disabilities or other communication needs are given ways to communicate when they are not around trusted adults, for example when they are in hospitals receiving treatment. We also need to make sure that there is a culture of acknowledging and recognising a disclosure and acting accordingly.

GROOMING

78. Notwithstanding the efforts of Grace Tame in raising awareness of grooming, most people do not understand what grooming looks like and how perpetrators purposefully target vulnerable children via grooming the adults around the child. There are considerable misconceptions about grooming, and child sexual abuse, and victim-blaming attitudes are still all too common. Groomers are incredibly smart and manipulative and capable of using complex behavioural strategies to create an environment that allows them to perpetrate sexual abuse.

79. We need to educate people to identify the components of grooming and act on red flags and boundary breaches before the grooming can lead to child sexual abuse. This can be achieved by educating the community about what grooming looks like, providing examples and educating people to identify these components. People should also be encouraged to report behaviour that may be a precursor to child sexual abuse.

80. Children in out of home care are more vulnerable to grooming because they often have additional and complex trauma backgrounds, such as coming from an abusive family or drug and alcohol dependence that can be taken advantage of by a perpetrator of child sexual abuse. I am aware of one example where the perpetration of child sexual abuse was identified when a staff member in out-of-home care identified that a resident had excesses of cash that could not be explained.

CULTURAL CHANGE AROUND INTERNAL REPORTING

81. There needs to be a whole population cultural change towards reporting observations of grooming-like and other inappropriate or overly familiar interactions with children both within organisations and within society more broadly.

82. Firstly, there needs to be a culture of reporting – an enabling environment. That is, people need to over-report instances of inappropriate behaviour or grooming-like behaviour that may signal the potential of child sexual abuse rather than under-report; the threshold for what is reported needs to be lower and more clearly understood.

83. Low reporting thresholds are important in protecting children from child sexual abuse. If minor issues are identified, corrected and dealt with constantly and

consistently, this deters perpetrators of child sexual abuse from committing child sexual abuse because they are aware that the system will be able to identify them. In contrast, reporting generally only occurs at high thresholds and, by the time a complaint is made, the perpetrator has already committed 'high-level' child sexual abuse against a child and left the environment. If we reaffirm that reporting is for the purpose of protecting children from child sexual abuse rather than prosecuting offenders, the process will be more effective.

84. I believe that there is an opportunity for concerns about grooming within organisational contexts to be approached in a similar way to how workplace health and safety is addressed — that is, through a hazard identification, reporting and then risk assessment. Using the workplace health and safety analogy, a person sees a power cord running across a floor and immediately report it and action would be undertaken via the hierarchy of controls (e.g., eliminate, substitute, redesign, educate/administrative controls). Reporting the conduct of adults could be addressed in this way where it becomes normal and expected to document and report grooming-like behaviour and actions are implemented to prevent the continuation of this behaviour (e.g., education, supervision, formal warnings, reporting).

85. A shift in culture to will also serves an educative purpose because it brings awareness towards 'lower-level' inappropriate or concerning behaviours that we still need to be aware of and stop.

86. Any notion that perceived 'low-level' inappropriate conduct by a person is 'just how they are', such as quirkiness or over-affection, should be expressly rejected. Everyone who works in an institutional setting should consistently be alert and err on the side of caution when it comes to making a report about child sexual abuse.

87. Secondly, it needs to be acknowledged that reporting someone for perceived problematic behaviour is not a black mark against that reported person's name but an acknowledgement that the system is working.

88. But, this is not how the system currently works and it has been my experience that some people can be overly concerned about the impact on the lives, careers and reputations of potential perpetrators when there is an allegation of inappropriate or concerning conduct towards children.

89. We should work to create a culture that normalises and encourages reporting, so that we can recognise inappropriate or concerning behaviours, irrespective of severity, correct them, and move on. That is how I want to see reporting work.

MANDATORY REPORTING

90. Since moving to Tasmania I have held senior roles where a key aspect of my role has been to support staff with fulfilling their mandatory reporting requirements and to ensuring the safety and well-being of children while in the care of the organisation I worked for. As such I have had frequent discussions with many staff about the barriers to reporting and their concerns about their interactions with Child Safety and the Advice and Referral Line (and its predecessor, the Gateway), and also became very familiar with the usual process and was able to speak frankly with the ARL or other child safety workers about my expectations for the next steps following the report, and what we our organisation could do to support the safety of the child.

91. It has been my experience that when it comes to mandatory reporting there is inconsistency between reporting thresholds between individuals and between organisations. I have always encouraged a low threshold for reporting in my teams and interactions with other workers in other organisations, but I am aware from my discussions with people working in different settings that the threshold for reporting in some settings (including some health services, schools, childcare centres and disability organisations) were much higher than I believe they should be. In many instances, the workers in these settings have wanted evidence of abuse or neglect, rather than reporting risk of harm.

92. Because Tasmania is small, reporters face an added element of stress linked to the risk that the alleged perpetrator will find out that they made the report and the adverse reactions and retaliations that might follow. It can be difficult to protect the anonymity of reporters as the details of the report by their nature often make the reporter identifiable. There is a need for more education and support for reporters about how they can talk to children, young people and their families about their mandatory reporting responsibilities, the specific circumstances of their report and what is likely to happen following a report to the ARL.

93. I have heard from workers across a range of settings since the change to the ARL they feel less supported as they do not know the person they are reporting to, and the person they are reporting to does not know the systems and services in the North and NW of the state. Previously, workers had been able to develop local relationships with the Gateway and Child Safety staff who were based locally and understood local services and community dynamics. I recognise there is a key balance to be struck in providing a locally responsive services, and in ensuring that the anonymity of victims and perpetrators and avoiding potential biases affecting how the matter is reported and investigated.

94. Generally, a standard conversation with ARL is bureaucratic. The conversation starts with a number of simple questions to identify the caller and locate them on the system. When it comes to information about the child and the instance, the information gathering is also bureaucratic, and a number of reporters I have supported over the years have felt that the information they have provided has been dismissed as invaluable by the ARL. There should be greater emphasis on thanking a reporter for the information they shared, reassuring them that all information is valuable, encouraging them to call again with any further information, and giving them suggestions to seek support and exercise self-care.

95. I have been told by some reporters that they have experienced pushback from the ARL or Child Safety Services (CSS) following a report. For example, they were asked by staff at Child Safety Services what the service should do with the report. But, people that are required to report under the reporting scheme do not necessarily have that knowledge. All they may know is that they are required to make a notification.

96. I have also been told by reporters that they get off the phone without any understanding of next steps, and without any knowledge of whether they have discharged their mandatory reporting obligations or of their role in the process moving forward. In some cases, the reporter is told that the Advice and Referral Line or Child Safety Services will be in touch, but then no follow up call happens. There should be checks and balances in place to prompt follow up calls.

IMPLEMENTATION OF THE ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE RECOMMENDATIONS

97. It is my understanding that the Tasmanian Government is still working towards the enactment of the Child Safe Organisations Bill 2020.

98. The draft Child Safe Organisation Bill 2020 contained alternative principles for the Safety and Wellbeing of Children and Child Safe Standards. I do not understand why the National Principles for Child Safe Organisations were not directly adopted without amendment as the Royal Commission and Human Rights Commission have already spent significant time and resources outlining best practices in this area.

99. The child safe framework should have the effect that organisations that do not meet the National Principles for Child Safe Organisations will not be funded by the Tasmanian Government. The Tasmanian Government should commit funding to running programs and making certain training mandatory for staff of institutions that interact with children. This training should include information about the drivers of gender-based violence, the warning signs of violence, tactics of perpetrators when grooming, ways to respond to disclosures, how to discuss mandatory reporting responsibilities and the limits of confidentiality, the role of ARL, CSP and TasPolice, and documentation of their observations, interactions and responses when they are concerned about children. The Tasmanian Government should also implement frequent and mandatory compliance reviews and reporting so that high standards are maintained, particularly in relation to the quality and consistency of reporting child sexual abuse.

100. However, to require institutions to consistently be reviewing and reporting on their compliance means that the Tasmanian Government must provide institutions with the resources necessary to implement this. It will be relatively easy for large State Government organisations like the Department of Education or wealthy private schools to meet the onus of reporting requirements. However, I am concerned that smaller institutions may be unable to meet the costs of compliance.

101. Despite the consultation for the Child Safe Organisation Bill which closed on 19 February 2021 recommending the acceleration of the implementation of child

safe standards and a reportable conduct scheme, we are yet to see progress about the reportable conduct scheme. When it is enacted, it needs to have clear and explicit examples of behaviours that are inappropriate and behaviours that are appropriate to clearly establish the thresholds for reporting. The reportable conduct scheme should also provide funding for an educative component that makes clear what the threshold for a reportable event is, and also makes clear that the threshold is much lower than many people or organisations think it is. For example, if a teacher shows photos on his or her phone to a student from a holiday overseas and one of those photos is in a revealing swimsuit that should be reported, whereas many people may currently not consider that as reportable conduct.

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

Declared at Hobart
on 3 May 2022

[redacted]
Kathryn Fordyce

Before me:

.....

Name of Witness

Capacity of Witness