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

WITNESS STATEMENT OF MARK BARRIE MORRISSEY

I, Mark Barrie Morrissey of [redacted] consultant and former Commissioner for Children and Young People (Tasmania), do solemnly and sincerely declare that:

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

Background and qualifications

2. Since January 2018 I have been, and I am currently, self-employed as a consultant in the field of child safeguarding and humanitarian/international aid.
3. Prior to commencing this role, I was the Commissioner for Children and Young People, Tasmania (**CCYP**) between September 2014 and October 2017.
4. I have a Bachelor of Registered Nursing from the University of New England completed in 1989. I have participated in ongoing education over the course of my career with a focus on children and young people.
5. Prior to appointment as CCYP in 2014, my roles between 1998 and 2014 included:
   (a) Executive Director-Child and Adolescent Community Health and Child and Adolescent Mental Health, WA Health, West Australia;
   (b) Director Child and Adolescent Health State-wide Policy, West Australia; and
   (c) Director State Policy, Child Protection, Department of Communities, West Australia.
6. Attached to this statement and marked **MM-1** is a confidential copy of my curriculum vitae. I have an extensive background in child and adolescent health and wellbeing that includes child protection, child health, child development and child and adolescent mental health.

7. This statement is based on professional observations, experiences and recollections between 2014 and 2017. For illustrative purposes I have focussed on several incidents, issues and challenges. Comments are made to the best of my memory and are in no way a complete or summative recollection of all issues. I have endeavoured to present information factually and honestly, to the very best of my ability to recall events of several years ago. I respect the right of others to hold differing opinions and recollections on the events and issues I discuss.

8. I do not have reference to the documentation I produced as CCYP between 2014 and 2017. However, for those who may have access to these documents and file notes, I am confident they will support the commentary.

9. It is important to note and acknowledge that on many important reform matters, the agendas of the government and CCYP were collaborative and productive. This included Government acceptance of and progress on reform recommendations contained in several CCYP reports and reviews between 2014 and 2017.

10. However, certain CCYP recommendations were delayed. These included:

    (a) much needed reform at AYDC; and

    (b) the establishment of a Child Safe Organisation (CSO) framework. If children and young people are to be kept safer from all forms of abuse, CSO safeguarding is a priority, for all organisations working with children, both Government and non-government.

Personal statement to those who were harmed and abused by institutional failures

11. Recent reports of child abuse and systemic failures within state institutions in Tasmania, are deeply distressing and disturbing.

12. To those people who shared your stories of abuse with the Commission of Inquiry, I heard your testimony and acknowledge your pain and bravery in coming forward.

13. As a former CCYP, my thoughts, care and concern are with every child, young person, adult and their families, who have been directly affected by abuse.

14. The institutions and systems that were meant to protect you, have failed you.

15. My hopes and wishes are that the work and recommendations of the Commission of Inquiry will be carefully considered and adopted by state institutions and organisations, to ensure your stories that you shared with great bravery, will make a difference and will not be forgotten.

16. All children and young people, including future generations, have a right to be free from abuse, have a right to be listened to and believed.

Ashley Youth Detention Centre (AYDC)

17. The CCYP is the Advocate for individual young people incarcerated at AYDC. The responsibilities of this role are specified within the *Commissioner for Children and Young People Act 2016* (Tas) (**CCYP Act**).

18. As the Advocate for young people at AYDC, I was on the public record calling for significant changes and reform at AYDC. My rationale in calling for reform is stated below.

19. A primary focus of investment for society and government should be early intervention and prevention. It is self-evident that preventing problems before they occur is a very worthwhile endeavour. For example, striving to ensure at risk children do not enter the youth justice system in the first instance. However, should children be about to enter the youth justice system, access to a range of evidence-informed diversionary programs are crucial to ensuring children are diverted away from the youth justice system, especially detention, which by its very nature, is harmful. The myriad of issues being faced in youth justice, both in Tasmania and nationally, are ultimately the result of longstanding failures to focus on early intervention and prevention. However, current issues require a more immediate response.

20. Sexual predators are drawn to institutions wherever children are present. This knowledge pre-dated the release of the report of the Royal Commission into Institutional Responses to Child Abuse (2017), ipso facto, AYDC has always been a high-risk institution with potential for the sexual abuse of children and young people.

21. Child safeguarding measures at AYDC, in my assessment, were below par. Promoting and encouraging organisations to adopt the CSO safeguarding framework was one of my key agendas as CCYP. This focus included AYDC.

22. It is important that children are regularly informed about and understand the child safeguarding systems that are in place. The systems in place must be meaningful to them and they have confidence that there will be a response if they report a concern or abuse.

23. I do not believe that children at AYDC had confidence that their reports or concerns would be adequately responded to.

24. The application of all principles within the CSO framework is essential guidance to ensure the safeguarding for all children and young people, especially those at AYDC.

25. In this context, I released the CCYP Report titled 'Strengthening Child Safe Organisations' in 2015, which is attached to this statement and marked **MM-2**.

Developmental disorders and young people detained at AYDC

26. Most children and young people detained at AYDC have significant developmental disorders related to significant childhood trauma and related brain injury. These children are some of the highest need and vulnerable children in our community. They have a right to trauma informed, professionally led, care and treatment. As I was observing, to place these children in detention and, at times, in isolation, will exacerbate the existing brain trauma which will lead to a worsening of their behaviours and disorders. A therapeutic milieu is essential.

27. A critical component required in responding to their needs is the provision of specialist child and adolescent mental health services. Capacity to provide these services was a key issue for the Tasmanian Government. The complex mental health and developmental needs of young people at AYDC were not being adequately addressed.

28. Childhood mental health disorders are often a forgotten problem.[1] If leaders and decision makers are to respond adequately to the needs of these children and the factors that contribute to these children's offending behaviours, they will need to seek to better understand these children.

Therapeutic milieu as an essential component of rehabilitation

29. A new purpose-built physical facility for this small group of high need children, as announced recently by the Tasmanian Government, is to be welcomed.

30. However, the parallel development of an evidence-informed model of therapeutic and rehabilitative care is of primary importance. A contemporary model of care, that acknowledges these children that have a developmental disorder, along with the design of the new facility, will together have the potential to create a therapeutic milieu – both ingredients essential to rehabilitation and treatment.

31. Form should follow function. This principle states that the form/shape of a building should primarily relate to its intended purpose and function. Ipso facto, the current design, appearance and management of AYDC at Deloraine, is likely to have negatively impacted on children incarcerated there. It is a given that if children's needs are not adequately met and they suffer abuse, it is highly likely their behaviour will be challenging in return.

32. Whilst the recommendations I made for reform at AYDC were accepted by Government, this did not translate into the establishment of a well-developed, and evidence informed model of therapeutic care, essential for children in detention.

33. Additionally, a therapeutic environment is underpinned by a CSO framework. This is the essential safeguarding foundation of a well-developed therapeutic model.

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[1] Michael G Sawyer, Holly Erskine, Alyssa CP Sawyer, Mark Morrissey and John W Lynch, Childhood mental disorders: A forgotten problem? (2015) *Australian and New Zealand Journal of Psychiatry*, Volume 49, Number 9, pp 774-775.

34. An additional and significant factor impacting on outcomes for AYDC detainees is the relative geographical isolation of the facility, well away from the necessary therapeutic professional services, given its location at Deloraine.

35. I was of the view that AYDC should be closed, and a smaller therapeutic facility be constructed closer to Hobart or Launceston.

AYDC as an enabler to young people's criminal trajectory

36. Many of those on the AYDC custodial workforce were often poorly equipped and without the experience and skills necessary to effectively work with vulnerable children. At its heart, this is attributable as a workforce capability and recruitment practice issue.

37. AYDC is a youth detention centre very much in need of reform. It is apparent that young people at AYDC experience unacceptably high rates of recidivism and readmissions. This is a significant "red flag" indicator that substantial systemic issues exist within the current AYDC model of care.

38. Highly vulnerable younger children, often as young as 12 years of age, were regularly in the company of older children who were highly experienced in criminal activity and with links to extensive criminal networks outside AYDC. These older children became role models for impressionable younger children.

39. Crime naïve children, on first admission, often experienced AYDC as a period of apprenticeship wherein they gained new and additional skills in the commission of crime and anti-social behaviours. I recall conversations with younger children who proudly shared their stories of new crime skills they were acquiring at AYDC.

40. Young people, following their first and subsequent admissions to AYDC, are introduced to older children with established juvenile criminal networks and friendships that then extended beyond AYDC.

41. Their criminal pathway, further reinforced at AYDC, often led to subsequent offending, eventuating in ongoing involvement with the justice system.

42. AYDC was a place, for many young people where they met other incarcerated young people and established relationships with criminal network families who

offered the young people a "de facto family" who provided a sense of belonging and community - a "family" support network that they had previously been deprived of. These "alternate" support networks offered stable housing, an income (from crime), a sense of belonging and connection, which however, due to its very nature, increased the likelihood that the young people would continue a life of crime, compounding their trauma and likelihood of future incarceration.

43. Young people entering the "pointy-end" of the youth justice system need to be provided with an opportunity for rehabilitation and to transform life trajectories. However, detention at AYDC was a period of lost opportunity, usually resulting in young people being released back into the Tasmanian community having established friendships and skills that ensured poor life outcomes.

44. I formed a view that the option of community-based supervision was underutilised with too many young people being held on remand at AYDC, with unnecessarily negative consequences, as already discussed. Suitable options were often unavailable beyond AYDC.

AYDC's lack of a therapeutic model of care is a lost opportunity

45. The longstanding absence of a therapeutic and trauma informed model of care at AYDC has resulted in a "generational revolving door" situation wherein generational incarceration became the norm.

46. These children and young people are incarcerated due to society's failure to provide a "good enough" start to life. Life course trajectories are correlated with the non-medical factors that influence health outcomes, known as the Social Determinants of Health (**SDoH**). The SDoH have a profound impact on the early years of a young person's development. In the absence of adequate protective factors, they will be overcome by the cumulative burden of trauma, neglect and the complexity of their life situation.

47. A very small number of these children will enter the justice system and AYDC. However, the absence of a therapeutic milieu and skilled response at AYDC has continued to fail these children.

48. It is important to positively acknowledge those staff at AYDC, both custodial and professional, as well as Departmental staff, who have strived to make a positive difference.

49. I have held many conversations with such people. They have shared their experiences of prevailing culture and an outdated model of care, that has been a source of frustration and professional disappointment.

Culture as an enduring force at AYDC

50. The prevailing culture within AYDC has existed, largely unchallenged, for many decades and continues to drive poor outcomes for this cohort of young people. In my assessment, the prevailing culture was counter to therapeutic outcomes. The needs of both government and AYDC staff, although different, often unstated and subtle, were prioritised over the needs of children.

51. It is unclear to me how often the "best interests of children" principle was considered and applied.

52. This focus on the needs of adults (and organisations) over the needs and rights of children resulted in adultism as the prevailing driver within this facility.

53. Some newly recruited staff often left AYDC, after a year or two, as they were unable or unwilling to internalise and accept the prevailing culture. However, others who were more easily socialised into the dominant and prevailing culture, remained on staff at AYDC for many years. This in effect, further consolidated the enduring "detention centre" culture that has prevailed at AYDC for decades.

54. In my observations, a commonly held implicit or unstated understanding by AYDC custodial staff was that their role was to be custodians first and foremost, akin to prison officers. Rehabilitation appeared to be very a much lower order priority.

55. Prevailing culture is a key driver of institutional values and behaviours. My observation was that custodial staff at AYDC were working within a static institutional culture that was by its very nature unable to be forward thinking or offer therapeutic care that was in the best interests of children.

Breaches of conventions

56. Under the Convention on the Rights of the Child (**CROC**), children have rights including:
    (a) the right to be heard;
    (b) the right to health;
    (c) the right to education, play and recreation;
    (d) the right to an adequate standard of living; and
    (e) the right to be protected from harm and abuse.
57. The model of care at AYDC was failing to meet these rights in several key areas.
58. From a national perspective, I believe that as a nation we have failed, and continue to fail, young people held in detention. Youth justice offending issues are the result of the long-term failure of child wellbeing policy and systems nationwide. The nation's approach to youth detention is "not fit for purpose" and is in direct conflict with the CROC to which Australia is a signatory. CROC principles affirm:
    (a) non-discrimination;
    (b) the best interests of the child;
    (c) children's right to survival and development; and
    (d) children's right to participate in decisions that affect them.
59. Within this context and through the CROC lens, AYDC and the Government have continued to fail to meet the human rights obligations they owe the children and young people incarcerated at AYDC.
60. Examples include:
    (a) the right to health care. At AYDC there was an absence of a trauma informed therapeutic and rehabilitative model of care, noting that most children in AYDC have a developmental disorder. Healthcare for young people with developmental disorders, must incorporate and prioritise trauma informed care that includes psychological, emotional and developmental health.

(b) the right to be protected from sexual abuse. Article 34 of the CROC states children have a right to be protected from sexual abuse and exploitation. All children are vulnerable to sexual abuse in institutions but children in detention are especially high risk.

(c) the right to be protected from abuse and neglect. Article 19 of the CROC states children have a right to be protected from abuse and neglect by their parents, or anyone looking after them. The state of Tasmania as custodian of these children and as the parent (for children on child protection orders) has a duty to ensure the protection of these children and young people.

61. Further, in my observations, AYDC was in breach of several articles of the Optional Protocol to the Convention against Torture (**OPCAT**).

62. This included the use, on occasions, of isolation, humiliating treatment of young people by certain custodial staff and the use of excessive force.

The issue of equity and access

63. Traumatised, disadvantaged and psychologically injured young people in detention are not afforded the comparable professionally led, high-quality access to care provided to young people in the mainstream community.

64. A comparative example I have often used to illustrate the need for a therapeutic model of care for youth detention, is the situation wherein a child or young person in the general community, is severely injured in an accident and is transferred to a hospital for treatment.

65. In that example, on arrival at the hospital the seriously injured child is promptly triaged and professionally treated by a team of appropriately skilled and experienced healthcare professionals. Once stabilised the injured child remains in hospital until discharged and on the path to recovery, then returns to the community for rehabilitation and aftercare.

66. By comparison, young people in detention are not afforded comparable levels of care.

67. There is a need for access to comparable levels of skilled care for young people in detention, delivered by staff who are competent to work with severely traumatised and highly vulnerable young people.

68. Whilst children and young people who are transferred to AYDC do not have apparent physical injuries, they are often seriously injured in equally significant ways. They often have serious psychological or emotional damage and issues, brain injury due to childhood trauma or conditions such as fetal alcohol spectrum disorder (**FASD**), family violence, chronic neglect, failed attachment and developmental delay. Due to a myriad of accumulated traumas, these children are often psychologically, spiritually and emotionally wounded. They have a right to high quality therapeutic care and rehabilitation, which AYDC is unable to provide. This failure to provide rehabilitation and therapeutic care can often have catastrophic effects on life trajectory.

69. In my observation between 2014 and 2017, the Government did not implement a genuinely therapeutic model of care. I am unable to speculate as to the reasons.

70. I held many conversations on the need for and benefits of a therapeutic model of care at AYDC with Government and the Department. I was of the view that custodial staff at AYDC should be trauma informed, skilled paraprofessionals, working as a team with a range of professional staff, providing a multidisciplinary response.

71. Attached to this statement and marked **MM-3** is a public media release my office issued when I was CCYP, dated 30 August 2016, which records some of the efforts being undertaken in relation to AYDC as well as my view that, at that time, "the current model in place at Ashley does not provide the necessary therapeutic support".

Changing the narrative about children and young people in detention

72. My recollection of attitudes towards young people incarcerated at AYDC, is of a community that had accepted the status quo. The implicit message I was receiving was that AYDC was not a subject for discussion. Incarceration as the solution was not questioned.

73. However, the narrative about this small group of young people can be changed by education and engagement with the community on this issue.

74. Young people in detention are some of the most disadvantaged in our society. These young people often perceive that the world has treated them unfairly and respond accordingly. The reality is that several environmental factors have in fact contributed to their perception. These factors include experiencing child abuse, family violence, poverty, family with a history of criminal activity, expulsion from school, lack of agency, developmental disorders and absence of significant positive role models in their life.

75. Their stories need to be told. Unless the root causes are understood, community appetite for the status quo will continue. Organisations involved in youth justice, including governments, should seek to share with the community the developmental circumstances of these young people. These young people are much more than the crimes they may have committed. Their behaviour is symptomatic of the damage and trauma brought about by the families, communities and organisations who failed to adequately care for and nurture them.

Department of Education school within AYDC

76. The exception to the AYDC experience, located within this outdated correctional facility, was the Department of Education school (**AYDC School**), an exemplar of high-quality teaching staff achieving good outcomes for highly disadvantaged and traumatised young people.

77. The AYDC School was an in-reach service provided by the Tasmanian Department of Education and was a "shining light" at AYDC. The AYDC School was led by a remarkable principal (who I understand retired in 2017) along with several skilled and experienced teachers. Functionally illiterate young people would often be reading and writing within a year of commencing as students of the AYDC School. In my conversations with the young people, they consistently expressed how much they valued the school.

The need to actively seek the views and experiences of young people at AYDC (and the failures to do so)

78. Article 12 of the CROC states that children have a right to participate in decisions that affect them.

79. Soon after commencing as CCYP in 2014, I prioritised the establishment of regular meetings/conversations with the young people at AYDC. It was immediately apparent that effective and satisfactory mechanisms were not in place for young people to raise concerns, report abuse, make complaints or share experiences.

80. In my mind this situation was of "red flag" concern. The likelihood of significant issues being unreported was high. I formed a view that AYDC was not a Child Safe facility.

81. During 2014, I observed that young people were not being encouraged to speak up, make complaints or bring their concerns to AYDC management and staff. In some instances, there appeared to be processes in place that prevented young people's voices being heard. In effect, there were no identifiable mechanisms in place for the department to consult with, or listen to, the young people within AYDC.

82. My usual practice was to visit AYDC at least once a month during my tenure, in order to meet with the young people. Initially, I was advised that there must be a custodial staff member always standing close by, during meetings. This practice was restrictive and unsatisfactory and in effect ensured that the young people I met with would have very little to say or disclose.

83. To better improve consultations and conversations with young people, I negotiated with AYDC management that I meet the young people in a room where I could safely meet young people on a one-on-one basis, with the ability to hold a private conversation. In the context of CSO principles, I always ensured that a worker would be able to observe through a glass door, however, be out of earshot of the conversation. After a year or so, most of the young people would come and meet with me at every visit. At no time did I feel at risk or threatened by the young people. The interactions were usually engaging and open.

84. I was unable to meet on a one-on-one basis with any of the female detainees. However, I met with a few young female detainees, with the guards present. Reluctance to meet with a male was most likely due to several factors including distrust of males, which is understandable. As a strategy, I offered female detainees the opportunity to meet a suitably skilled member of the CCYP staff, which occurred on a few occasions. I increasingly formed a view that AYDC was highly unsuitable for detained young people in general, however it was especially unsuitable for highly vulnerable young females. Concerningly, the male detainees outnumbered the female detainees significantly, noting that at times some young men were detained for offences of a sexual nature.

85. The lack of consultation with young people and lack of understanding on the part of AYDC staff and management, of the importance of seeking the views and experiences of young people in detention speaks to the shortfalls within the model that was in place at AYDC during 2014 to 2017. I actively promoted the message that in order to keep children and young people safe, their views and experiences must actively be sought and that they must be listened to, believed and have action taken, where appropriate.

86. In the absence of processes to listen to young people, it was likely that abuse would be unreported.

87. For illustrative purposes, I will share an experience that related to young people reporting abuse and making complaints at AYDC. I raised the matter of young people's right to be heard, including the importance of actively seeking out and listening to children and establishing reporting strategies to identify abuse, with the Department and AYDC management. After a time, in response to my requests, AYDC management installed a complaints box for the young people to make complaints or raise concerns. Whilst I am confident this strategy was put in place with the very best of intentions by AYDC staff, it illustrated to me the need for a better informed and evidence-based model of care at AYDC. I recall that the complaints box was brightly coloured and placed in a prominent position in the AYDC dining room. The prominent position of the complaints box concerned me for the obvious reason that it was unlikely to be used, given its location.

88. In effect, if any young person wished to make a complaint it had to be put in writing (noting that many detainees were functionally illiterate) and placed

publicly in the complaints box. This example of a fundamentally flawed strategy was also further exacerbated by the fact that the dominant ethos of young people at AYDC was that you "don't dob". The chances of a young person placing a complaint or concern in the box were close to zero. Interestingly I was advised by AYDC management that "the young people rarely if ever make complaints so I was not to expect very much".

89. I was not made aware of any complaints going into the complaint box between 2014 and 2017.

90. Not listening to, or seeking, young people's views and experiences (an important component of CSO principles), will result in high-risk environments for children. Such a context is inherently unsafe for young people, often allowing critical incidents and abuse to remain unchecked, unreported and out of sight. I was concerned at the lack of available information and oversight regarding the safety of young people at AYDC. Strategies to safeguard children were well below acceptable minimum standards, for such a high-risk environment.

91. High-risk environments such as AYDC, require a child safeguarding framework that is prioritised and deeply embedded into every aspect of the organisation.

92. The absence of effective complaint mechanisms and the low volume of complaints being received from young people, was a significant "red flag" and cause for concern.

93. In response to this situation and in order to empower and encourage detainees to have a voice and to speak up, I developed and placed educational posters around AYDC, encouraging young people to meet with me as their advocate and, if they wished, to raise issues. I also encouraged the detainees to contact my office at any time. I subsequently received calls from young people at AYDC, often after hours.

94. I also spent time in the schoolrooms, the lunchroom and the grounds establishing relationships with the young people, to build trust and to better understand their experiences. I was hoping this would help to keep them safer and enable me to better fulfil my role as their individual advocate. Progress was initially slow in building trust and openness, however this improved with time.

95. As I became more familiar with the facility, I raised concerns about day-to-day issues within the AYDC facility. This included safety issues related to the cells,

CCTV blackspot coverage, quality of the food, recreation availability on weekends and issues of boredom the young people experienced.

96. Safeguarding processes for groups who were highly vulnerable, such as female detainees, younger detainees and those with a significant disability were of concern.

97. I also raised concerns regarding suicide risk, which were promptly addressed by the Department.

98. The main themes of concern raised in conversation with the AYDC detainees included:

    (a) not being listened to by staff;

    (b) complaints being ignored;

    (c) being sworn at by certain staff members;

    (d) being belittled by certain staff;

    (e) being locked in their cells alone for extended periods of time, especially on weekends, with a lack of activities; and

    (f) excess use of force.

99. In some instances, I would ask the young people to share their complaints verbally for me to hand deliver to AYDC management. When possible, I would discuss issues directly with management staff or hand deliver the written complaints or feedback to the management.

100. When I followed up to inquire about progress on individual complaints submitted by detainees, the advice I often received from AYDC management was "they're sitting in someone's in tray" or "can't be found". I flagged this issue with the Department. This issue was never adequately resolved.

Recollections and reflections on AYDC

101. In the role of CCYP it was not within the legislated powers to take any direct remedial action, aside from direct advocacy with the Minister for Child Protection, the Department and AYDC management. I raised concerns on a

range of issues, both formally and informally, however responses varied according to the issue.

102. I was informally advised by a senior person at AYDC that "reform was difficult to progress. It was a closed culture".

103. During my tenure as CCYP I do not recall being advised by the Department of any incidents of alleged sexual abuse.

104. However, there were incidents of alleged physical assault that I became aware of through my networks, which had been escalated to police and the Department. I was not invited to participate in the review process nor informed of the details of these incidents. One memorable incident involved several guards forcibly returning a young person back into a cell. This incident was captured on CCTV. This matter was referred to the police for investigation. I believe this incident could have been much more effectively managed by skilled custodial staff who understood the importance of de-escalation and therapeutic relationships.

105. On occasion I witnessed custodial staff restrain young people. My recollection is that the response appeared heavy handed and excessive.

106. In my experience, the Department was reluctant to share information on incidents that occurred at AYDC. To the best of my recollection, reviews of AYDC, such as the Harker and Noetic Reviews into AYDC, were also not shared with my Office, noting the Noetic Report was subsequently publicly released.

107. On several occasions I witnessed incidents of verbal abuse and belittling of the young people by certain AYDC staff. I reported these incidents to AYDC management however was not advised of the outcome. The custodial staff involved in this abuse remained on staff at AYDC. It concerned me that such verbal abuse had become normalised, and staff were willing to speak to the young people in my presence, in such a manner.

108. At times, I would make additional unannounced visits to AYDC, which I was entitled to undertake as the CCYP. When I made such visits, on occasions it was difficult to obtain access to the facility and the young people. At times I left AYDC without being able to meet with detainees. My assumption is that this may have been related to reduced staffing levels and young people being confined to cells to a greater degree on weekends.

109. On one occasion in 2014 during a pre-arranged routine visit I was allocated a room at AYDC to meet with detainees. I was accompanied by a CCYP staff member. Upon entering the room, it was locked from the outside. However, the young person was not escorted to the meeting as anticipated. My staff member and I were left in the meeting room without access to a phone and no ability to leave the locked room, as the door was locked from the outside. To the best of my recollection, we remained locked in the secure room for between 60 and 90 minutes. At the time, AYDC staff offered no rationale for what had occurred. I raised this incident formally with the Department and received a letter of apology stating that it had been an oversight. I formed a view that the incident may have been a deliberate act, signalling that I was not welcome to meet with the young people at AYDC.

110. By late 2014, I began to form a view that culture and a "status quo" approach were significant issues at AYDC. Addressing this would require deep reform and leadership that challenged the status quo.

111. The Government responses to my recommendations for AYDC were not of the extent and breadth I believed were needed to establish a genuinely therapeutic and rehabilitative model of care.

112. Reflecting on many conversations with the young people, my lasting memory is that of so much lost opportunity and potential for both the institution and the young people.

113. I consistently endeavoured to work respectfully and collaboratively with the Government and the Department, when calling for a therapeutic model of care at AYDC. The CCYP office undertook research and analysis of relevant models of care to assist with Government and Departmental deliberations.

114. Reform at AYDC has been historically slow and difficult. For example, over 30 years ago, I accompanied a group from the Royal Commission into Deaths in Custody on an inspection of AYDC. They expressed concern that AYDC was not fit for purpose. In the subsequent years, very little substantially changed, and the facility remained unfit for children and young people. A key component of rehabilitation is accommodating young people in facilities that are conducive to rehabilitation.

115. Some decades ago, AYDC was a working farm. The young people had access to farm-based employment, opportunities to learn new skills and the ability to expend youthful energy in a productive way. The farm is no longer operational. Between 2014 and 2017, whilst there were some skill-based activities, such as a barista program and a workshop, such activities were limited.

116. Accomodation options on release were limited. For example, there was an instance where a detainee was discharged from AYDC in winter, to live in a tent as there was no suitable alternative solution. Departmental staff often had very limited accommodation options to offer. Suitable accommodation options are essential for young people on release from detention. Without these options, the chance of reoffending is greatly increased.

117. Many young people told me that readmission to AYDC was often welcomed. I spoke to some young people who admitted committing crimes in order to be re-admitted to AYDC. At AYDC they had food, a roof over their heads, a degree of safety and friends.

118. Lack of housing is a key factor in reoffending. Many young people told me they felt safer in custody at AYDC than living on the streets or couch surfing.

119. In my assessment, AYDC's *raison d'etre* was less focussed on the best interests of vulnerable young people and more focussed on providing local employment and to lock away "problem kids". Noting that there was an appetite for this approach from sectors of the community.

Political support for the status quo at AYDC

120. During 2017 I received a phone call from a senior Government politician (who I respectfully choose not to name) asking me to "back off AYDC" as the "boys were criminals" and that AYDC was doing a good job. This caller commented that AYDC was keeping the community safe and that AYDC was providing important employment to the Deloraine region. I offered to meet with the politician to discuss further. The caller made it very clear that there was nothing further to discuss. I shared the information about this call, in confidence with a senior CCYP staff-member however decided not to share this information any further.

121. In essence, the economy of Deloraine was being prioritised over vulnerable children's best interests and safety. I formed a view that the closure of AYDC was a closed topic.

122. As the AYDC issue was a particularly contentious and sensitive political issue, I made the decision to continue to advocate for changes at AYDC predominantly out of the public arena. I endeavoured to maintain respectful and open lines of communication between my office and the Government. I formed a view that if I was to remain influential and as an agent for change, this strategy was likely to be the most effective strategy.

Out of home care (OOHC)

123. I will preface my comments on OOHC with an observation that issues in OOHC are common across Australia. However, in certain aspects, the situation in Tasmania was unique. Significant gaps existed in the oversight and monitoring of vulnerable children in care.

124. During 2014 to 2017 there was very little structured monitoring of kids in OOHC. "Monitoring" was mainly the responsibility of often over-worked individual Departmental caseworkers. I was also very concerned at the absence of independent monitoring of children in OOHC.

125. Heading into my third year as commissioner, I had become increasingly concerned and alarmed that Tasmania had not yet established adequate standards for OOHC or other accountability mechanisms for the OOHC sector.

126. Many children and young people in OOHC in Tasmania are often highly traumatised and required specialised support and care. In several key areas, the OOHC system was not adequately equipped and staffed to care for these kids.

127. Vulnerable children who are taken into care have a right to the best care available. My professional experiences with children in OOHC, over many years, was a constant reminder of the need for adequate resourcing and much greater institutional compassion for these children who come into state care.

128. In response, I developed a Report that recommended monitoring of children in OOHC, which was released in January 2017. Attached to this statement and marked **MM-4** is a copy of that report, titled 'Children and Young People in Out of Home Care in Tasmania' (**CCYP OOHC Report**).

129. The CCYP OOHC Report was fully accepted by government, and I understand progress in the implementation is occurring. I do not feel the need to elaborate on the contents of the CCYP OOHC Report, as the report speaks for itself.

130. Between 2014 and 2017, following wide-ranging and extensive face to face consultations with children in OOHC, OOHC carers, Departmental staff and OOHC NGOs, it was evident that significant issues existed in Tasmania. In essence, as of 2017 many children in OOHC remained in unsafe and poorly supported placements across Tasmania.

131. I do not propose to unpack in detail the issues identified in the CCYP OOHC Report as the report itself substantively does this.

132. Noting that there are also many very capable and kind foster carers who do a remarkable job however there were also those who were less than ideal carers.

133. As CCYP, I wasn't made aware by the Department of any contemporary cases of child sexual abuse within OOHC. The Department kept such matters as confidential. However, there were many historical cases, informally brought to my attention in conversation with various individuals within my network.

134. The CCYP has no legislated mandate to respond to individual cases of child abuse. Contemporary or recent cases of abuse were not brought to my direct attention during my time as CCYP. The relevant legislation was clear that any allegation of sexual abuse needed to be reported to the Police and Department.

135. My advocacy on OOHC with the Government and the Department was undertaken respectfully (and in confidence on sensitive issues), in order to build and preserve a respectful and collaborative relationship with the Government.

OOHC options for children with challenging behaviours

136. OOHC options for children with challenging behaviours were in short supply in Tasmania.

137. One example comes to mind. For many years the Department was sending young people with challenging behaviours to a program in the Northern Territory. There was significant resistance from the Government to call an end to the contract despite concerns raised by parents and some stakeholders. I am aware that this program has subsequently been defunded. Tasmania needed a range of local accessible programs for at risk young people with challenging behaviours.

Allegations of historical abuse: listening to young people and believing them

138. As an illustration in relation to allegations of historical abuse and the response to such allegations, I will provide a summary of one matter brought to my attention. As this case occurred in 2016, there may be aspects of my recollection that are not specific on certain details.

139. In 2016, a young man requested a meeting with me at the CCYP offices. He was [redacted] years old at the time. During this meeting, a senior and very experienced member of the CCYP staff was present. The young man disclosed to me that he had been abused in OOHC. He was distressed as he shared his story. I recall he said the abuse occurred about [redacted] years previously. He advised he had reported the abuse to the Department however had not been believed or taken seriously. I recall he said he was living in a group home [redacted]

140. I formally wrote to the Department and within a short period received a written response stating that there was no substance to the allegations being made by the young man. It was clear from the tone of the letter that the Department considered the matter closed.

141. I felt it was an unreasonably quick dismissal of a potentially very serious claim of abuse. In my view, it could not have been adequately re-investigated or case reviewed within that short timeframe and the dismissive Departmental response was very disappointing and concerning. Under the CCYP Act, I was unable to review details of this matter so am unable to comment on the substance of the complaint or quality of the investigation by the Department, noting that

contemporary research indicates that young people rarely make up stories of sexual abuse.

142. I advised the young man to recontact DHHS and to also seek legal counsel if possible. I also suggested he access counselling and support.

143. I am unable to recall the young man's name, however the letter I sent to the DHHS at the time will be on Departmental records, in addition to a file note I kept on record at the CCYP office.

144. Members of the public would often phone the CCYP office to raise individual specific complaints of child abuse, both current and historical. CCYP staff would always refer the callers to the Department and, if required, the police. However, based on the CCYP Act, the CCYP had no mandate to follow up these individual cases. Records of every call were kept by CCYP staff.

The need for an adequately funded independent mediator or advocate

145. A fully independent statutory role akin to a mediator, advocate or review panel, adequately resourced, that focuses solely on child abuse, should be established for those who are frustrated in their efforts to report both historical and current allegations of abuse, to seek a review of a case, or to report institutional abuse.

146. Whilst there are existing mechanisms such as the Health Complaints Commissioner, from my observation, I believe this area has been historically underfunded with a high volume of work.

147. Such a role could be a mediator and advocate between those reporting abuse and the Department. The focus would be on individuals who are not satisfied with the response they receive, or who are reluctant to report to the Department directly. This role would help to ensure accountability and transparency. Vulnerable and at-risk children and young people would be assured a more adequate and timely response.

148. The Royal Commission into Institutional Responses to Sexual Abuse has seen thousands of people come forward to report historical abuse. Their voices must be listened to, and action taken, in whatever form is required. In my experience,

the existing processes discourage many people who have suffered abuse from coming forward.

149. There have been too many instances of individuals who had alleged or suffered abuse, not being believed or not taken seriously when they endeavoured to report abuse. At times sanctions, manifest in many forms, are applied to individuals (both adults and children) who have suffered abuse and make the decision to speak out about perpetrators or institutions.

150. Not being listened to or not being consulted by adults such as caseworkers, legal practitioners, carers and teachers, was a key theme I observed in my conversations with children and young people in OOHC, Youth Justice and Child Protection. Many of these stories were distressing to hear. Life changing decisions were made about children's lives without seeking their input. Additionally, the therapeutic value of actively listening to and believing young people, is an important aspect of working with children in the care of the state. The same importance applies to adults who report historical abuse.

151. Sadly, key contributing factors to this situation included staff with excess caseloads, inexperienced staff, reporting processes that were not child friendly, lack of adequate staff supervision and professional practice that excluded the voices of children and young people.

152. I note that there were also many positive examples of Departmental staff working with children in an exemplar way.

The need for full implementation of a CSO framework

153. From 2014 onwards, I advocated regularly for the implementation of CSO frameworks across Tasmania.

154. On 29 September 2015, I publicly launched the CCYP report titled 'Strengthening Child Safe Organisations' (Attachment **MM-2**) at St Mary's College in Hobart.

155. However, between 2014 and 2017 there was limited interest and uptake of the CSO framework within DHHS or other Government departments.

156. However, I note that I recall the exception was the Department of Education whose leadership expressed a keen interest in CSO.

Department of Education (DoE)

157. During tenure as CCYP, I developed a positive and mutually respectful working relationship with the DoE. The recollection I have is that of competent and collaborative senior leadership within the Department. Support for the CCYP role by DoE was consistent and positive.

158. The DoE responded positively to the release of the CCYP CSO report of 2015, however the adoption appears to remain a work in progress.

159. With the support of the DoE, I established school-based consultation groups across Tasmania, during which time I met many hundreds of young people across the state. Most young people had a positive view of their school. No issues of abuse or harm were raised during consultations.

160. My observation was that DoE were proactively addressing key educational issues as they occurred, and genuinely striving to improve and reform educational outcomes for children and young people across Tasmania. I recall the very positive work in transitioning many high schools from year 10 to 12.

161. I note however, that I have recently had the experience of viewing some of the public broadcast of the Commission hearings in relation to education and the DoE, at the time of preparing this statement.

162. I was deeply saddened at reports of child sexual abuse and system failures within schools and the DoE.

163. Going forward, consideration should be given to developing protocols wherein important matters such as child abuse, are discussed with the CCYP, and consideration be given to the CCYP undertaking a review, under the CCYP Act. This process of collaboration would contribute to a stronger, more immediate and integrated approach to keeping children safer from abuse.

164. While there are legislative limitations on what the CCYP can do in relation to specific allegations of abuse, I believe an opportunity exists for reform and improvement by requiring better communication and information sharing

between authorities, government departments and the CCYP. This lack of information sharing is not an issue specific to any one department or authority and may help protect and support vulnerable young people engaged with all governmental departments.

165. I remain hopeful that the findings and recommendations of the Commission of Inquiry into Tasmanian Government's Responses to Child Sexual Abuse will substantially and significantly contribute to all Tasmanian children being safer and better protected from all forms of abuse.

Reflections on the CCYP role

166. Comments made are based on my experiences during 2014 to 2017.

167. These experiences and reflections are offered respectfully, however with candour, to provide insights and information that may assist deliberations in the context of the CCYP's capacity to function effectively, in the best interests of children and young people.

168. I emphasise and acknowledge that on several important reform issues the Government and CCYP agendas between 2014 and 2017 were aligned and at times in agreement.

169. On issues of urgency and importance relating to the CCYP's oversight and advocacy responsibilities of the CCYP, I would regularly write to the Minister for Child Protection, to provide updates and advice. However, during a meeting with the Minister in early 2017, I was asked by a senior staffer who was present at the meeting, to cease writing to the Minister.

170. This appeared to be a request to change the CCYP's relationship with the Minister (and Parliament) and direct correspondence through to the Department.

171. However, I held the view that in order to fulfil the role of CCYP in a transparent and accountable fashion, I was obligated to continue to bring important matters to the attention of the Minister and ipso facto - the Government.

172. Documentation/correspondence to Government advocating for the best interests of children, is a key factor to ensure mutual accountability and clarity of communication. A paper trail also ensures access to historical records are

maintained on the record. On this point, I note that all correspondence from CCYP to the Minister was also copied to DHHS, for their records.

173. I also note that conversations were routinely held to discuss a wide range of issues in the spirit of collaboration, mutual advice, strategy and general information sharing.

174. During 2017, I was advised during a formal meeting, in the presence of other senior staff, by a senior officer (whose name I do not wish to provide) within government, that my approach to media engagement and public advocacy was "self-promotion".

175. I had no concern with an individual expressing a viewpoint. The concern I had related to an apparent attempt to undermine the *raison d'etre* of the CCYP – namely as an independent voice legitimately advocating for children and young people, particularly vulnerable and at-risk children.

176. The office of the CCYP requires a public presence and communication with the community on issues relating to children's well-being and safety, which is an important element of being an effective advocate.

177. Reflecting on many years in senior leadership roles, I have directly observed that governments can have cultures that are resistant to independent statutory roles providing constructive comments or advice. Various nuanced and, at times, subtle strategies are used to mitigate the effectiveness of such roles.

178. I recall a conversation with a senior Departmental officer, soon after commencing in the role of CCYP. The person was reflecting on how "if you go against the system, the system has a really powerful immune system, and it will react to you in a hostile fashion, if you make waves". This comment appeared to have been made as a "matter of fact" statement. I did not interpret the comment as any advice to me specifically. However, the conversation indicated that "a status quo approach would be welcomed".

179. There are various ways that the effectiveness of independent statutory positions can be lessened or influenced by governments and bureaucracies.

180. For example, one commonly applied strategy is to "turn the resourcing tap down, by increments and delay" – such as delaying recruitment to staff vacancies or

applying efficiency dividends. I have observed this strategy many times over the course of my career.

181. For example, during 2014 to 2017 the office of the CCYP was often staffed by two or three professional staff, due to extended (and puzzling) delays in Departmental approval to recruit to vacancy. This significantly limited the CCYP Office's ability to adequately fulfil the requirements of the role. The Department was responsible for providing corporate support to the CCYP, including finance, HR and IT. However, this "reliance on the Department" model can have an impact (it may be unintended) on the efficacy of a statutory role. It is self-evident that small functional areas such as the CCYP will feel the impact of delayed processes more significantly than a larger organisation.

182. The office of the CCYP, being dependent upon a government department for corporate and other support (such as finance, HR and IT), is potentially vulnerable to external pressures and competing priorities. This issue of external dependence can weaken the capacity of the CCYP to be fully functional, independent and productive. For example, the recruitment to vacant staff positions was often held up for extended periods, for reasons I was unable to ascertain. This directly impacted on the CCYP core business.

183. This model of external corporate support to the CCYP, contributes to potential for real or perceived conflicts of interest. The CCYP, at times, is required to hold to account the very Department on which it relies for resourcing and day to day operational support.

184. During 2017 in the role as CCYP I developed and submitted a business case seeking an increase in resourcing to progress a range of priority issues, including OOHC monitoring. The business case was approved at the time of my resignation. I understand four or five additional staff were able to be recruited. This outcome and support by Government for OOHC was commendable.

185. The CCYP Act is well drafted and enabling in many aspects. However, due to several subtle factors the independence of the role can come under pressure. There are many factors that can influence statutory roles. This may include, as mentioned earlier, "turning the resourcing tap", which can impact on the capacity of the CCYP. Going forward there would be merit in examining ways to mitigate factors that impede the autonomy of the CCYP office. An independent review of

the CCYP Act to strengthen the CCYP office's capacity to protect children and young people should be considered.

186. The existing arrangement, whereby corporate support for the CCYP is provided by the Department, appears to be a "custom and practice" matter and is not specified in the CCYP Act.

187. Such an arrangement raises issues of real or perceived conflict of interest. This would be addressed by the Office of CCYP having their own "stand alone" corporate capacity. I have observed over the course of my career, that statutory and advocacy roles can face financial/corporate impediments to adequately fulfilling their roles. This situation contributed to delays in responding to the needs of children and young people in Tasmania during my tenure.

188. The CCYP role is responsible to Parliament, as it clearly states in the CCYP Act. However, during 2014 to 2017, the primary relationship was with the Minister for Child Protection. As an unintended consequence of this arrangement, the CCYP role risks becoming narrowly focussed on child protection and child safety. This is a critically important area, however the CCYP role relates to all children and young people and as such, advocacy for the wellbeing of all children. In this broader context, the primary role ideally should not just relate to one minister.

189. It is self-evident that the potential exists for "sanctions' against those who speak up on matters of public interest. Governments and organisations at times limit or push back on people who speak up on matters of public interest that may be politically embarrassing or inconvenient. Recently, I have had contact with senior departmental ex-employees. These former departmental officers expressed reluctance to take part in the Commission of Inquiry process, due to perceived potential consequences on their career and reputation. These long-standing dynamics limit positive and constructive discourse on solutions to crucial issues facing children and young people.

190. It is a given that leadership roles including advocacy roles such as the CCYP, require strong and mutually respectful relationships with key stakeholders, in order to be successful, enduring and effective.

191. However, on all matters affecting children, including child safety, the foremost consideration must be the best interests of the child. There is an enduring risk

that individuals, organisations and governments may choose to protect and prioritise their own interests over that of the child. Over the course of my career, I have witnessed on numerous occasions, competing interests and agendas being prioritised over children's best interests. I also observed this during my tenure as CCYP in Tasmania.

192. Going forward, bold and visionary leadership is required of institutional leaders, in order to keep children safer. Child safeguarding cannot be left as a lower order priority or delayed.

193. To better safeguard children and young people, a shift is needed from the existing models of child protection to a public health approach, such as that outlined by the Australian Catholic University's project titled 'A public health approach to protecting children'.[2]

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

Declared at .....

on 9/8/2022

[redacted]

Before me

[redacted]

[Full name of Justice, Commissioner]

[2] https://www.acu.edu.au/about-acu/institutes-academies-and-centres/institute-of-child-protection-studies/our-research/current-projects/a-public-health-approach-to-protecting-children