TRANSCRIPT OF PROCEEDINGS

COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

At Hearing Rooms 6A and 7A
Tasmanian Civil and Administrative Tribunal,
38 Barrack Street, Hobart

BEFORE:

The Honourable M. Neave AO (President and Commissioner)
Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)

On 14 June 2022 at 9.33am

(Day 11)

1 PRESIDENT NEAVE: Ms Ellyard, I'm going to make some
2 orders first.
3
4 During previous hearings I explained that it will
5 sometimes be necessary for the Commission to make an order
6 which restricts the publication of certain information.
7 The Commission is committed to being open and transparent
8 respecting the preferences of victim-survivors and
9 considering the impact that evidence from these hearings
10 may have on the wider community.
11
12 This week the hearings are focused on a particular
13 institutional setting, namely out-of-home care. The
14 Commission recognises that evidence this week about
15 vulnerable families, young people and children may be
16 distressing, including for those who are working in the
17 system and who are trying to do the right thing.
18
19 In this context the Commission's general approach this
20 week will be to avoid identifying particular communities,
21 carers, families, young people with children.
22
23 Our first witness today is a victim-survivor who,
24 after careful consideration, would prefer not to be
25 identified. The Commission respects that preference. In
26 order to protect the identity of this victim-survivor and
27 other relevant people, the Commission has decided to make a
28 restricted publication order.
29
30 The Commission makes this order because it is
31 satisfied that the public interest in the reporting on the
32 identities of certain people who may be discussed during
33 this hearing is outweighed by the preference of the
34 victim-survivor and relevant privacy considerations.
35
36 I will now briefly explain how the order will work.
37 The order requires the use of a pseudonym; this means that
38 the witness to whom Ms Ellyard will refer will be called
39 "Faye" rather than by their real name. The order requires
40 that any information in relation to Faye's identity be kept
41 confidential. This means that anyone who watches or reads
42 the information given by Faye to the Commission must not
43 share any information which may identify Faye or the people
44 who will be referred to as "Allen Brady, Louis Brady or
45 Ruth Brady". This information is not limited to their real
46 names and may include other information which may identify
47 them such as where they live or work.

1
2 In order to protect Faye's identity she will not give
3 evidence personally; instead, I will invite Counsel
4 Assisting to read her witness statement. A transcript of
5 this evidence will be available in due course.
6
7 I make the order which will now be published. I
8 encourage any journalist wishing to report on this hearing
9 to discuss the scope of order with the Commission's media
10 liaison officer. A copy of the order will be placed
11 outside the hearing room and is available to anyone who
12 needs a copy.
13
14 Yes, Ms Ellyard, I decided to read this prior to your
15 opening just in case there are members of the press here so
16 they will know what is to follow. So, Ms Ellyard.
17
18 MS ELLYARD: Thank you. Commissioners, for this week of
19 hearings I appear with my learned friends, Ms Darcey and
20 Ms Rhodes, to assist you by calling evidence and making
21 submissions on the topic of the out-of-home care system in
22 Tasmania and how it responds and identifies the risks of
23 child sexual abuse.
24
25 I would like to begin by paying respect to the
26 traditional and original owners of this land, the Muwinina
27 people. I pay my respect to those who have passed before
28 us and acknowledge today's Aboriginal people of Tasmania
29 who are the custodians of this land.
30
31 The Commission's terms of reference call on it to
32 consider child sexual abuse in institutional settings and
33 out-of-home care is one such institution.
34
35 For the purposes of this week, a reference to
36 out-of-home care means the formal care that is arranged or
37 provided by the Tasmanian Government to children and young
38 people who are assessed as being unable to live safely at
39 home. It includes foster care, kinship care, sibling group
40 care, residential care and therapeutic services.
41
42 Children living in out-of-home care will have been
43 placed there by the state and will ordinarily be under the
44 guardianship of the Secretary to the Department of
45 Communities, or what used to be called state wards or wards
46 of the state.
47

1 It is important to note that in the past an important
2 and a common form of out-of-home care was orphanages and
3 children's homes. The Commission is very aware that some
4 children who lived in those institutions experienced abuse,
5 including sexual abuse, and that the effects of that abuse
6 have been profound and lifelong.
7
8 Because those bricks and mortar forms of institutions
9 are no longer part of the out-of-home care system in
10 Tasmania, and because the Commission's purpose and focus is
11 to consider the system now and how it can be improved into
12 the future, the stories of those who lived in orphanages
13 and children's homes won't be a focus of this hearing but
14 those stories which the Commission has heard and received
15 about the experiences of children in those settings are an
16 important part to the background of the evidence that we
17 will hear.
18
19 Children who are placed in out-of-home care will
20 usually have lived through a range of difficult and
21 traumatic experiences in their family of origin or in the
22 care system. Children in out-of-home care include an
23 overrepresentation of children with Aboriginal heritage,
24 children with disabilities and children with other
25 potential vulnerabilities. Many of these children are at
26 risk of falling out of sight of the broader community; they
27 overwhelmingly come from circumstances of disadvantage as
28 do their families of origin.
29
30 Sadly, the Commission has seen that some children
31 represent the second or even third generation of their
32 families to be in care. In many cases they will be
33 children who do not have access to the advocacy of their
34 parents or who might be less engaged at school, and so,
35 children in the out-of-home care system rely on that system
36 to meet their needs and to protect them from the risks of
37 harm including the risks of child sexual abuse. These
38 children need a system which protects them. One of the
39 questions to be asked this week is whether the system does
40 sufficiently protect this cohort of highly vulnerable
41 children from the risks of child sexual abuse, in the light
42 of evidence which suggests that, despite a decade of
43 ongoing reforms, some children are still at risk and some
44 of those children are being significantly harmed in
45 out-of-home care.
46
47 The other question that we will consider this week is

1 how the system responds when children in out-of-home care
2 do experience child sexual abuse. We'll explore the
3 policies and practices that are in place to respond to
4 allegations and how the system can be improved to support
5 children who are sexually abused, including how the system
6 can ensure that children receive appropriate therapeutic
7 supports to assist them to recover from the abuse that
8 they've experienced.
9
10 The community may not be aware of the process by which
11 children come to be in out-of-home care. Children in
12 out-of-home care in Tasmania are placed there after a
13 process which will ordinarily begin with a notification or
14 a referral to Child Safety Services through the Advice
15 & Referral Line about which the Commission has previously
16 heard evidence. The notification will suggest that the
17 child is "at risk".
18
19 Under the Children, Young Persons and Their Families
20 Act, a child will be at risk if they have been, are being
21 or are likely to be abused or neglected, or where their
22 guardians are unable or unwilling to prevent the child from
23 being abused and neglected.
24
25 After a process which will have involved investigation
26 by Child Safety Services and an application to the court, a
27 child can be made subject to an order which places them
28 under the guardianship of the Secretary. Such orders will
29 be made by the court where the court is itself satisfied
30 that the child is at risk and where the court is satisfied
31 that the order is necessary to ensure the care and
32 protection of the child.
33
34 Once the child is under the guardianship of the
35 Secretary, the Secretary is responsible for decisions about
36 where the child will live, their education, their medical
37 care and other aspects of their lives. They must consider
38 the best interests of the child in making decisions about
39 them and must provide for the child's physical,
40 intellectual, psychological and emotional development.
41
42 As the evidence will reveal, the Secretary meets that
43 obligation of providing for children under guardianship by
44 way of a system which has both governmental and
45 non-governmental components. Some out-of-home care is
46 provided by the state, other care is provided under
47 contract by non-governmental organisations and we'll hear

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1 further evidence today to explain that process in detail.
2
3 The National Royal Commission into Institutional
4 Responses to Child Sexual Abuse made, amongst its many
5 observations, the observation that the safety of children
6 in out-of-home care should be a priority. Children in care
7 have been forcibly removed from their families of origin
8 and placed in the care of the state to ensure their safety,
9 so the prevention of abuse in out-of-home care must be a
10 primary concern for the state.
11
12 The National Royal Commission also found that, despite
13 reforms to the sector, there are still weaknesses and
14 systemic failures that continue to place children in care
15 at risk of sexual abuse from three different directions:
16 firstly, from adults within the child protection system
17 such as foster carers or residential care workers.
18 Secondly, from adults outside of the child protection
19 system or placement, including through child exploitation,
20 and thirdly, at risk from other children in the system,
21 perhaps another foster child or another child in the care
22 placement who engages in harmful sexual behaviours.
23
24 Turning briefly to each of those three sources of
25 risks for children. The National Royal Commission found
26 that most adults in the out-of-home care system are
27 hardworking and committed individuals who provide children
28 the supports that they need, and no doubt that is also true
29 in Tasmania. But, the nature of out-of-home care means
30 that children are exposed to the potential risk of child
31 sexual abuse from adults within that system; from foster
32 carers and their families, from child safety staff, from
33 staff in the non-governmental organisations that are
34 contracted by the Department of Communities to provide
35 care. This means that how staff are recruited, trained and
36 supervised, what Codes of Conduct guide their work
37 practices, how other staff are supported to note and report
38 concerns about boundary blurring and investigations, are
39 all important ways in which the risk of child sexual abuse
40 from within the system can be managed and avoided.
41
42 Adults outside the out-of-home care system also
43 provide a source of risk to children, often through child
44 exploitation. Child sexual exploitation is where children
45 are coerced or manipulated into engaging in sexual activity
46 in return for something, perhaps a gift of alcohol or
47 money. The perpetrator often initially grooms these

1 children online. Sadly, there are adults who actively
2 target children in out-of-home care, particularly children
3 in residential care. Some of those adults use social media
4 to make less visible initial contact and develop
5 connections with children which then evolve into so-called
6 "relationships" which might not be recognised at the time
7 for what they are - inappropriate and abusive.
8
9 The National Royal Commission in its work identified
10 that even Child Protection staff and out-of-home care
11 workers and police can misunderstand child sexual
12 exploitation and misidentify it as "adolescent sexual
13 experimentation", or normal behaviour for children in
14 out-of-home care, or a "free choice" that's being made by
15 the young person.
16
17 The Commission will recall in week 1 of its hearings
18 you heard evidence from Associate Professor Tim Moore that
19 children in care, particularly in residential care, often
20 live in a dehumanised and sterile environment in which
21 no-one says that they love them, no-one hugs them. Such
22 children are desperate for connection and that makes them
23 vulnerable to adults who might make them feel special but
24 who then lead them into problematic and exploitative
25 situations.
26
27 The common factors for children who are sexually
28 exploited in out-of-home care include, firstly, having
29 experienced child sexual abuse on their family of origin,
30 or having a history of engaging in harmful sexual
31 behaviours themselves in their family of origin.
32
33 Across Australia there have been some well-published
34 and well-publicised instances of child exploitation of
35 children in care. One of those instances was a case which
36 horrified the Tasmanian community. Just over a decade ago
37 now a child was subjected to serious and prolonged sexual
38 exploitation while she was under the guardianship of the
39 Secretary. Some of those responsible were later convicted
40 and imprisoned, but the relevance of that awful case for
41 the work of this Commission is the process failures within
42 the Child Safety Services system, the system through which
43 the Secretary was exercising parental responsibility for
44 that child which led to the sexual exploitation being able
45 to occur. Those process failures were the subject of
46 internal and external reports at the time and some of the
47 many reviews which have been conducted into the child

1 safety and out-of-home-care system in Tasmania.
2
3 Turning to harmful sexual behaviours as the third
4 potential source of risk for children in out-of-home care.
5 As the Commission heard in week 1, harmful sexual
6 behaviours includes a range of sexual behaviours carried
7 out by children which are beyond their developmental age
8 appropriateness and which can involve coercion or violence
9 and which can be directed towards peers, younger children
10 or adults. And in fact this form of child sexual abuse is
11 the most prevalent and it can be very difficult to manage
12 in the out-of-home care setting because of the increased
13 presence of children in out-of-home care who have trauma
14 histories, including histories of child sexual abuse which
15 makes them at increased risk of either engaging in the
16 behaviour or becoming victims of it.
17
18 The National Royal Commission found that there are
19 organisational features of out-of-home care settings which
20 appear to increase the risk that children will engage in
21 harmful sexual behaviours in care and those organisational
22 features include normalising force as a part of male
23 sexuality; the attitude that girls are responsible for
24 defending themselves against abuse; a culture that
25 normalises sexual aggression as part of normal sexual
26 conduct or experimentation; a culture of silence regarding
27 sex and child sexual abuse in out-of-home care services
28 where child sexual abuse is not discussed with children;
29 lack of adequate training for staff to differentiate
30 between what is age appropriate behaviour and what is
31 abusive sexual behaviour between peers; a lack of
32 reporting; placing child sexual abuse victim-survivors and
33 those who have engaged in harmful sexual behaviours in the
34 same placement; having a higher ratio of men to women in
35 young people's residential care facilities; placing young
36 people with adjustment difficulties together; and finally
37 where a hyper-sexualised culture has developed during the
38 sexual abuse histories of children in the placement.
39
40 The Royal Commission made recommendations for
41 increasing the safety of children and protecting them from
42 this kind of abuse; it included adequate screening,
43 authorisation and training for carers and staff; ongoing
44 supervision and training on how to keep children safe;
45 adequate monitoring and supporting of out-of-home care
46 placements; regular visiting; creating opportunities to
47 talk with children on their own; directly observing carers

1 and their interactions with children, and establishing
2 residential care as a safe, supportive and therapeutic
3 environment for children with complex needs staffed by
4 skilled and experienced workers.
5
6 Turning from what's known and been revealed in the
7 work in other places, I turn to frame the size of this
8 issue for Tasmania.
9
10 In April 2022 there were just over 1,000 children
11 living in out-of-home care in Tasmania and that seems to
12 have been a number that's broadly consistent in
13 recent years. Most children were living in home-based
14 care, that includes kinship care and foster care, with a
15 small number in residential care.
16
17 The information provided to the Commission of Inquiry
18 by the state indicates that between January 2013 and July
19 2021 - that's an 8.5 year period - there were a total of
20 439 allegations received of child sexual abuse in
21 out-of-home care. Some children were the subject of more
22 than one report, so those figures represent 299 individual
23 children who were the subject of at least one report. 439
24 allegations over 8.5 years equates to, on average, 52
25 allegations a year or one allegation per week, and of
26 course we know that child sexual abuse is underreported
27 both at the time and even many years later.
28
29 Of the 439 allegations made over that period, 289
30 related to girls and 150 to boys. 122 of the allegations
31 related to children who are Aboriginal. 120 of the
32 allegations related to children who had a disability, and
33 in both cases the true number may be higher because not all
34 files recorded that information about the child who was
35 alleged to have been harmed.
36
37 So, what these figures received from the state
38 indicate, that roughly one in every 36 children in
39 out-of-home care is the subject of at least one allegation
40 of child sexual abuse. To understand those figures
41 provided by the state better those working for the
42 Commission have selected 22 children for a deeper file
43 review. That review included being provided with the
44 relevant Child Safety Service files for those children,
45 including case notes, reports and reviews, and that process
46 enabled the Commission to form a clear picture of the
47 pattern of issues and outcomes for those children.

1
2 From those 22 cases, four have been selected to serve
3 as case study examples in the course of this hearing. The
4 case study examples raise themes of harmful sexual
5 behaviours, sexual exploitation, the recruitment and
6 support of carers, the need for therapeutic responses for
7 children who have experienced trauma, the proper resourcing
8 of the Child Safety Service system, and the inherent
9 complexities of the cohort of children who live in
10 out-of-home care.
11
12 Those case studies have been de-identified to protect
13 the children involved; they'll be used to examine the ways
14 in which the systems did or did not respond to meet those
15 children's vulnerabilities and needs. What those case
16 studies will show is that this is a highly complex and
17 challenging area of professional practice; there are
18 sometimes no clear answers to the issues with which carers
19 and Child Safety Officers are confronted, but the case
20 studies will also show examples of children being exposed
21 to preventable harm because the systems didn't respond as
22 they should have when clear risks of sexual abuse were
23 present.
24
25 Important evidence relevant to this week's themes was
26 given in week 1 by a number of witnesses, including
27 Dr Burton of TasCOSS, Ms Sonya Enkelmann, Associate
28 Professor Tim Moore, Dr Michael Salter, Professor McDermott
29 and Dr Malvaso. In particular, some of that evidence was
30 about the Child Safety Service and the policy structures
31 which guide its work. It's important to note that, of
32 course, the Commission is not inquiring into the Child
33 Safety Service more generally, but the evidence is that
34 there are aspects of that structure's work and operations
35 which directly affect how well the out-of-home care
36 component of the Child Safety Service system can work to
37 protect children.
38
39 Dr Burton gave evidence of observation made by TasCOSS
40 members about the out-of-home care system and its
41 intersection with Child Safety Services. Members working
42 in that sector believe that Child Safety Service officers
43 are very overloaded and overstretched. There are workforce
44 issues about training staff, the turnover, recruitment and
45 retention. The combination of the lack of staff training
46 and the high workloads, in Dr Burton's assessment, meant
47 that there was a very high threshold for reporting and

1 responding to child sexual abuse.
2
3 Dr Burton said that member organisations of TasCOSS
4 are ready to implement the National Standards for Child
5 Safety and to work under a consistent broad framework that
6 includes accreditation for carers, a Carers Register and a
7 Reportable Conduct Scheme, but they need guidance and
8 support from the government to develop and implement a
9 consistent and robust structure for their operations.
10
11 Other witnesses this week will pick up that theme of
12 the importance of standards, the absence of sufficient
13 monitoring of the quality of care provided to children in
14 out-of-home care, and the extent to which the system
15 tolerates a level of risk for children in out-of-home care
16 which it would not tolerate for children in the broader
17 community.
18
19 Ms Sonya Enkelmann's evidence was that the Department
20 of Communities has a reputation for being closed and
21 defensive with a crisis-driven and reactive approach. She
22 observed in her time there a hesitancy for genuine open
23 consultation and a focus on maintaining control of the
24 message. She concluded that there were some wonderful
25 outcomes being achieved in out-of-home care because of what
26 she called sterling individuals and the relationships that
27 they had developed, but that those good outcomes weren't
28 because of the system.
29
30 She concluded that in some circumstances there was
31 inadequate support for carers, that children were not
32 routinely and consistently provided with therapeutic
33 support so that they could form healthy attachments. In
34 the case of residential care where children are not in a
35 home environment, the continuity of well qualified workers
36 was important so that children could form meaningful
37 relationships.
38
39 Ms Enkelmann noted that case managers are people that
40 children wanted to have a safe relationship with, but many
41 children and carers never or rarely saw the case manager
42 because of the case manager's high workloads or because of
43 the high turnover which made it difficult to form
44 relationships of trust.
45
46 Ms Enkelmann thought that case managers were
47 themselves at risk of vicarious trauma because they were

1 unable to provide the services and the job that they wanted
2 to do with the resultant burnout and a high turnover of
3 staff because of stress.
4
5 Ms Enkelmann noted that out-of-home care workers, who
6 she saw as incredibly dedicated and committed, had
7 unsustainable caseloads too, meaning that they were
8 essentially restricted to crisis work. Ms Enkelmann's view
9 was that the inability of the system to meet the child's
10 needs and to support the carer to understand the child's
11 needs meant that the child became more vulnerable to harm
12 so that the out-of-home care system itself had the
13 potential to become abusive.
14
15 Ms Enkelmann told you in her evidence that her work at
16 the department had included work on the development of
17 out-of-home care standards, a model for Family-Based Care
18 and continuous improvement frameworks, but all of that work
19 appears to be part of a long line of recommendations that
20 have been made or work done but that hasn't been
21 implemented.
22
23 Again, many of Ms Enkelmann's observations will be
24 echoed in other evidence that you will hear this week;
25 evidence about the demanding nature of the work in this
26 area and about the ways in which under-resourcing, a lack
27 of training and support and gaps in policy are all
28 combining to place children at risk or to result in
29 inadequate responses when they do experience harm.
30
31 There will also be evidence about what is perceived by
32 some to be an adversarial relationship that develops
33 between Child Safety Services on the one hand and foster
34 carers and advocates on the other, and a concern being
35 expressed that sometimes it's a delicate balance to be
36 struck between advocating for a child and falling foul of
37 the powers that be in Child Safety Services with potential
38 consequences for the child being removed or future advocacy
39 being less successful.
40
41 All of this evidence raises questions of both policy
42 and culture. Recalling the evidence of Professor Palmer
43 and Dr Guerzoni in week 1, the question to be posed is:
44 does the out-of-home care system have a culture that is
45 focused on the safety of children and do its policies and
46 practices serve that goal?
47

1 The evidence to be called this week will reveal that
2 the out-of-home care system as part of the broader Child
3 Safety Service system has been under review and subject to
4 change for over a decade. These reviews have included
5 reviews both from within government and from external
6 agencies like the Commissioner for Children and Young
7 People. Between 2011 and July 2021 there were nine
8 relevant reports, all of which made recommendations; many
9 recommendations were accepted by the government. When one
10 looks to those reports, many of the themes emerging from
11 them are the same themes that are going to emerge this
12 week: lack of support for carers; poor recruitment
13 practices; insufficient training and support; inappropriate
14 placements; children being permitted to live away from
15 placement; inadequate monitoring of children and of
16 out-of-home care providers, including of their funding
17 arrangements; poor record-keeping; poor information
18 sharing; the lack of accreditation, registration and
19 licensing systems for out-of-home care providers; poor
20 support for children's own participation in decision-making
21 process; and poor compliance with the Aboriginal and Torres
22 Strait Islander placement principle, coupled with an
23 overrepresentation, as I have said, of Aboriginal children
24 in out-of-home care.
25
26 The evidence will be that there have been new systems
27 introduced and new initiatives planned, but the strain on
28 the system and on the workforce remains, and it appears
29 there may continue to be an absence of clear and consistent
30 policies and standards to guide and direct Child Safety
31 staff, foster agencies and carers in the important work of
32 protecting children from child sexual abuse and responding
33 to child sexual abuse where it occurs.
34
35 The Commission heard in week 1 about the importance of
36 Child Safety Standards and Reportable Conduct Schemes.
37 Although both are foreshadowed, neither are yet in place in
38 Tasmania. Work on standards for out-of-home care has been
39 in train for some time but there are no finalised standards
40 in place.
41
42 Such standards have existed at a national level since
43 2011 and many other national non-government providers
44 comply with them, including ones who work in Tasmania and
45 in other states.
46
47 The Commission has heard from witnesses who have been

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1 engaged to work on new initiatives, like Ms Enkelmann, and
2 programs to improve Child Safety responses about the way
3 they've been sidelined or about how those programs have not
4 been implemented.
5
6 Turning to the question of how we can hear the voices
7 of children this week. A number of expert witnesses have
8 already told the Commission about the importance of
9 listening to children and of systems being designed with a
10 child's perspective in mind, and so it's important of
11 course that the Commission's own processes follow that
12 model and ensure that voices are heard.
13
14 In week 1 of the hearings the Commission heard from
15 Associate Professor Tim Moore about his work engaging with
16 children and young people in Tasmania to explore their
17 perceptions of safety within institutional contexts.
18 Professor Moore and his colleagues interviewed children
19 from each of the institutional contexts that are being
20 considered by the Commission, and that included children
21 who had experienced living in out-of-home care.
22
23 Professor Moore's final report is not yet available,
24 but the comments made by children who participated in the
25 study about what made them feel safe or unsafe in
26 out-of-home care are powerful. Their perspectives
27 highlight what the National Royal Commission has said about
28 the risks which children in out-of-home care face and I
29 want to take the opportunity to quote from some of the
30 things that those children have said.
31
32 Firstly, it's important to note that some children had
33 positive experiences of Child Safety Services workers. A
34 15-year-old girl who lived in out-of-home care said:
35
36 *I think most of them are doing well. They*
37 *will advocate for your situation and they*
38 *will talk to you, make sure you're okay.*
39 *Obviously, if something's going on they are*
40 *most of the time good at helping. When I*
41 *was not in a very good place I was talking*
42 *to my carer at the time and she went to my*
43 *Child Safety Officer and by Child Safety*
44 *Officer got me into Headspace and it worked*
45 *out in the end.*
46
47 Another child, also female aged 15, said:

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1
2 *Before it was quite stressful because we*
3 *didn't have a good caseworker. Our new*
4 *worker does her job really well and we are*
5 *in contact with her most of the time.*
6
7 However, other children consulted in the study
8 reflected on the impact of not having a worker available.
9 A 17-year-old boy said:
10
11 *I didn't even know my caseworker back then.*
12 *I don't have one now. I'm on an order but*
13 *I don't have one. Child Protection have*
14 *not assigned me a caseworker, I haven't got*
15 *one, but I've got someone higher up who's*
16 *trying to fill those shoes but you're not*
17 *doing the same job because you're not*
18 *seeing me.*
19
20 Some children had experiences of not being heard when
21 they expressed concerns. A 16-year-old boy said:
22
23 *I remember saying I wanted to go to a*
24 *different house because I was being*
25 *assaulted by a peer, I don't want to be*
26 *here.*
27
28 And he said:
29
30 *I said to my carers, I'd be like, please*
31 *don't let the peer come back.*
32
33 And the carer said:
34
35 *It's going to be fine. It wasn't. They*
36 *should actually listen.*
37
38 Some children reported that they live with amazing
39 carers who care for them, support them and protect them
40 from harm. For those young people the carers needed to not
41 only be warm and caring but also to be able to deal with
42 the trauma and the behaviours that the children might be
43 engaging in because traumas had not been appropriately
44 treated and resolved.
45
46 Some children interviewed reported that workers were
47 able to take quick and decisive action when they had

1 concerns and to move them to another house if that was
2 appropriate, but this required that they had access to
3 their worker and that the worker believed them and that the
4 worker took their concerns seriously and that other care
5 options were available for them and that wasn't always the
6 case.
7
8 One 17-year-old girl said:
9
10 *I tried to tell people, "This isn't working*
11 *and this is what they're doing" and they*
12 *didn't believe me because my foster carer*
13 *said that I was being a little hoodlum and*
14 *I'm stealing. I was doing this, I was*
15 *stealing food out of the cupboard because*
16 *they didn't feed me.*
17
18 The introduction of the role of the Child Advocate as
19 a position inside the Department of Communities was seen by
20 some as helpful. One 17-year-old girl said:
21
22 *I had met the Child Advocate through a*
23 *group that we did, so I knew her and I*
24 *texted her and I was like, "This isn't*
25 *okay", and she was like, "Sure, okay", and*
26 *then she dealt with those two times that I*
27 *needed here. She will get you out of an*
28 *unsafe situation immediately. If there's*
29 *an actual problem she does this detective*
30 *thing where she dives deep in the case and*
31 *as soon as she finds something wrong she*
32 *rectifies it, and because she's a bigger*
33 *person they immediately snap into action*
34 *and do what they need to do.*
35
36 *But I think it's scary if you don't know*
37 *her. She's a very higher up person. It's*
38 *scary to contact someone like that*
39 *especially if you're 12. Imagine you've*
40 *never heard of her and someone says, "Oh*
41 *you should go to the Advocate." As a young*
42 *child you're like, "Okay, how do I do*
43 *that?" Normally you would ask your parents*
44 *or the adults but if the adults are the*
45 *people you're having trouble with, then you*
46 *know you can't rely on them.*
47

1 The young people who Professor Moore spoke to believed
2 that sometimes the system felt that it was fine to move a
3 child from an unsafe circumstance and thereby reduce the
4 risk, but they didn't necessarily appreciate what the child
5 or young person needed to heal.
6
7 A 17-year-old female said:
8
9 *It's weird because the system, you expect*
10 *it to know how trauma works but the way*
11 *they act suggests that they don't. The way*
12 *they act is that six months of therapy will*
13 *fix you, or as soon as you move out of that*
14 *dangerous situation the triggers are gone.*
15 *But that's not how it works. That's not*
16 *how a kid's mind works. That's not how*
17 *anybody's mind works. It's going to*
18 *linger. That's going to stay with that*
19 *kid.*
20
21 That same young woman spoke about the absence of
22 support and understanding for their past experiences and
23 how she had to manage her trauma alone. She said:
24
25 *People just need to let things out, and*
26 *some people let things out through family*
27 *and friends, but some people don't have*
28 *those people, and some people have just*
29 *such complex emotions that they need to see*
30 *a therapist. It's just reminding kids of*
31 *these emotions and helping them through*
32 *them will probably stop the violent*
33 *behaviours.*
34
35 She went on to say:
36
37 *Sometimes I just feel like I can't turn my*
38 *emotions off, and my brain just goes into*
39 *rational mode. That's how I got through*
40 *it. I compartmentalise a lot and I shove*
41 *things down and then six months later I'll*
42 *start crying about the really scary things*
43 *that happened because, yeah, I have done a*
44 *lot of mental gymnastics to try and deal*
45 *with what I've been through and I'm*
46 *starting to unravel them, but it's really*
47 *hard to unravel a triple hexagon in my*

1 *head.*
2
3 The Commission will recall that in week 1 we heard
4 evidence from Professor McDermott about his review which
5 had identified the absence of suitable mental health
6 support for children in care and plans for a new CAMHS
7 service to meet that need. Those interviewed by Professor
8 Moore echoed that evidence about the need for that service.
9
10 One young man who'd experienced significant childhood
11 abuse and unresolved trauma which he felt led to his mental
12 health issues recalled that because of an absence of
13 support he was placed involuntarily in hospital.
14
15 He said:
16
17 *I ended up going to hospital because I had*
18 *suicidal thoughts because of my trauma and*
19 *my pain and my stress from everything that*
20 *had happened. They don't give a fuck about*
21 *trauma; they just label you with something*
22 *and throw you in a ward.*
23
24 Placement decisions, where children were placed, is
25 another theme that emerged in the discussions that
26 Professor Moore had with young people. One child said:
27
28 *I was in a placement with these kids. They*
29 *had never been in care before. And one of*
30 *them, I think she was 13, she was quite*
31 *violent and aggressive. And it was*
32 *shocking to me because she was such a*
33 *lovely girl most of the time. And then if*
34 *she got angry, it just happened and you*
35 *wouldn't expect it. I think if you already*
36 *have a child in your care that is not*
37 *stable or sensible you shouldn't put other*
38 *children there that have a background with*
39 *people like that. You just shouldn't put a*
40 *kid there full stop.*
41
42 *I wasn't scared of her being able to hurt*
43 *me, I was more scared for her safety. She*
44 *would try to run away. And their parents*
45 *were very violent. If they found them,*
46 *they would not hold back. I feel bad for*
47 *their situation. But at the same time I'm*

1 *also in a bad situation, so I need to be*
2 *able to feel safe where I'm not having to*
3 *be constantly anxious about what might*
4 *happen next.*
5
6 A 15-year-old girl in out-of-home care.
7
8 I expressed the gratitude of the Commission to the
9 young people who participated in Associate Professor
10 Moore's work. Of course, in addition to those young people
11 the Commission has also heard directly from
12 victim-survivors who have told their stories in meetings
13 with the Commissioners, or who have provided evidence in
14 submissions and confidential witness statements and we know
15 that all those perspectives will be brought to bear in how
16 the Commission frames its findings and its recommendations.
17
18 As we embark on the coming week of evidence and
19 picking up on remarks made by the President, we acknowledge
20 that this will be a very distressing time for many people
21 for many reasons.
22
23 Firstly, it will be a distressing time for survivors
24 of child sexual abuse in out-of-home care, it may bring
25 back intrusive and painful memories for them.
26
27 Secondly, it may be very upsetting for parents whose
28 children are in out-of-home care to hear about the
29 experiences of other children who were not kept safe. It
30 may make them worry about whether those awful things have
31 happened to their children and about whether they can be
32 confident that their children will be protected from harm.
33
34 Thirdly, it can be expected that staff in the
35 department who already feel under pressure and whose role
36 is a difficult one even in ideal circumstances, will feel
37 uncomfortable at this degree of external scrutiny of their
38 work, even though the focus is not on individuals, but on
39 systemic issues which affects the safety of children and
40 staff.
41
42 Fourthly, foster and kinship carers and the
43 organisations which support them may feel that their hard
44 work and commitment to caring for vulnerable children is
45 being undervalued or dismissed or tainted by association
46 with examples of poor practice.
47

1 It's not our intention to cause anybody distress. We
2 recognise that these are very difficult conversations and
3 that the work done by all in this area is professionally
4 and personally challenging. The vicarious trauma which
5 many staff and carers carry with them is real. We
6 recognise that decision-making and staff behaviour can be
7 influenced by that trauma, as well as by the supports and
8 processes that surround their work.
9
10 In calling the evidence this week we recognise, too,
11 the efforts of many working in the broader child safety
12 system and out-of-home care system. There can be no doubt
13 that many children are safer in their kinship or foster
14 placement than they would otherwise be, and there's no
15 doubt that many children in out-of-home care are thriving,
16 supported by carers, Child Safety Officers, therapists and
17 other supports in their local community. There will be
18 children who grew up in out-of-home care who were protected
19 from harm while in care, whose concerns were responded to
20 appropriately and who were supported to heal from past
21 trauma. But at the same time the evidence will be that the
22 system has failed to prevent sexual harm to some children
23 in state care and that it has failed to respond to sexual
24 harm when it has occurred.
25
26 There can be no doubt that the system needs to be
27 improved and that the many reviews and innovations proposed
28 over the last decade have not achieved that improvement.
29
30 Recalling the evidence of Professor Palmer from
31 week 1, an organisation that is designed to prevent child
32 sexual abuse needs to be what he called a "high reliability
33 organisation". It needs to be an organisation that
34 welcomes analysis and examination of near misses. It needs
35 to empower staff to recognise and act on signs of grooming,
36 exploitation and abuse. It needs to foster a culture where
37 it's okay to discuss the risks of child sexual abuse and
38 where children are encouraged and supported to come forward
39 if they have been abused; such a system will be better for
40 children, it will be better for carers and it will be
41 better for staff.
42
43 Turning then to the structure of the evidence this
44 week. Today, after hearing the story of victim-survivor
45 Faye who, as the President has indicated, has elected not
46 to give oral evidence but who has given permission for her
47 statement to be read, the Commission will hear from the

1 current Executive Director of the Children and Families
2 section of the Department of Communities, Ms Claire Lovell.
3
4 Ms Lovell's evidence will set the scene for the week
5 by describing the current structure and operation of the
6 out-of-home care system, the respective roles of government
7 and non-governmental organisations and how child sexual
8 abuse allegations in out-of-home care are received and
9 investigated.
10
11 After Ms Lovell, the Commission will hear from
12 Dr Robyn Miller, the CEO of MacKillop Family Services and
13 the former principal practitioner in the Child Protection
14 Division of the Department of Health and Human Services in
15 Victoria. Dr Miller's evidence will describe best
16 practices in keeping children safe in out-of-home care
17 settings, including the importance of educating and
18 supporting carers, having child-centred systems and
19 conducting deep dive reviews for children in care.
20
21 Then in the final session for today we will hear from
22 Dr Kim Backhouse of the University of Tasmania and
23 Dr Julian Watchorn of the Foster and Kinship Carers
24 Association of Tasmania.
25
26 On Wednesday we'll consider the particular risks of
27 child sexual abuse for vulnerable children who are in or
28 who could be in the out-of-home care system. Jodie Stokes
29 from Anglicare will give evidence about young people who
30 are at risk of homelessness but who may not be receiving an
31 out-of-home care response.
32
33 Heather Sculthorpe, the CEO of the Tasmanian
34 Aboriginal Centre will give evidence about some of the
35 particular needs of Tasmanian Aboriginal children and the
36 structures which could best serve them.
37
38 Her evidence will be followed by the evidence of
39 Professor Muriel Bamblett and Mr Richard Weston, who will
40 describe approaches in Victoria and New South Wales for
41 Aboriginal children in out-of-home care.
42
43 We will then hear from two witnesses, Caroline Brown
44 and Jack Davenport, about their experiences and
45 observations of the out-of-home care system in Tasmania,
46 and then in the afternoon expert evidence on the causes and
47 treatment of harmful sexual behaviours will be given by

1 Dr Gemma McKibbin and Ms Jenny Wing.
2
3 On Thursday we'll look again to other jurisdictions,
4 in this case Queensland and South Australia, about their
5 models for effective oversight and advocacy for children in
6 out-of-home care. We'll hear from a witness who was
7 sexually abused in foster care by a foster family member
8 and by another member of her local community in
9 circumstances where Child Safety Services were largely
10 absent from her life although she was in the Secretary's
11 care.
12
13 Then we'll hear evidence from a number of
14 representatives from foster care agencies regarding the
15 systems and processes which they use and those which they
16 are required to use by the department to protect children
17 from the risk of sexual abuse. There will also be evidence
18 on Thursday from Tasmania Police about the powers and
19 responsibilities of police in disrupting child sexual abuse
20 and investigating allegations of sexual abuse.
21
22 Finally on Friday we'll hear firstly from a
23 victim-survivor whose experiences of sexual abuse in
24 out-of-home care contributed to his trajectory of juvenile
25 and adult criminal offending. And then evidence will be
26 called from three key office holders in the governmental
27 structure relevant to out-of-home care: firstly, the Child
28 Advocate, a position created three years ago in response to
29 one of the reviews that I've mentioned; secondly, the
30 Commissioner for Children and Young People who carries out
31 systemic monitoring of the out-of-home care system; and
32 finally, the Secretary of the Department of Communities who
33 will answer questions arising from the evidence heard this
34 week and from the case reviews that the Commission has
35 conducted into cases where there were allegations of child
36 sexual abuse, exploitation and harmful sexual behaviours.
37
38 The Secretary's evidence will also be an opportunity
39 for the Commission to understand the current progress of
40 reforms which have been announced or which are in train,
41 including the proposed transfer of the Child Safety
42 Services into a new Department of Education, Children and
43 Young People.
44
45 The Secretary's being called not only because he's the
46 head of the department which provides or contracts for the
47 provision of out-of-home care, he's the guardian for nearly

1 all children in out-of-home care. He's their parent. And
2 whether the system permits him and the community to be
3 confident that the children in his care are safe and
4 protected from child sexual abuse is the ultimate focus of
5 this hearing, and we will welcome his views and responses
6 to the matters that are raised during this week's evidence.
7
8 If the Commission pleases, I'll now call on Ms Rhodes
9 to introduce and read into the transcript the evidence of
10 Faye.
11
12 PRESIDENT NEAVE: Thank you, Ms Ellyard. Before Ms Rhodes
13 does so, I just wanted to remind any journalists and others
14 who are present that there is an order in relation to the
15 evidence of the person "Faye", and that the order will be
16 posted on the door of the hearing room.
17
18 MS ELLYARD: As the Commission pleases.
19
20 PRESIDENT NEAVE: Thank you, Ms Rhodes.
21
22 MS RHODES: Thank you. I'm reading from the sworn
23 statement of the person known as "Faye". There have been
24 some redactions made to the statement to protect her
25 identity and potential other victims.
26
27 I'd first like to thank Faye for trusting the
28 Commission with her statement and for allowing me to read
29 it into the record:
30
31 *I grew up as part of a large family. My*
32 *siblings were all older than me. After an*
33 *event neither of my parents were in a*
34 *position to care for me or my siblings for*
35 *any extended period.*
36
37 *I was placed in foster care for the first*
38 *time when I was young and moved in and out*
39 *of foster care from this time. I would go*
40 *back to one of my parents between foster*
41 *placements. My parents weren't in a*
42 *position to look after us.*
43
44 *In the mid-90s when I was in late primary*
45 *school my sibling and I were placed with a*
46 *foster family in Tasmania. The foster*
47 *parents were named Ruth and Allen Brady.*

1 *Another sibling was placed in a different*
2 *foster home and I don't recall what*
3 *happened to my other siblings.*
4
5 *Ruth and Allen were older parents at the*
6 *time, they had a nice home. I would*
7 *describe them as being well off. They had*
8 *lots of food. It felt comforting being in*
9 *a home with all of these things after*
10 *growing up so poor. Their parenting style*
11 *was strict but offered stability and*
12 *structure. This stability was very*
13 *different to what I had experienced with my*
14 *own family and was something I needed at*
15 *the time.*
16
17 *The Bradys had biological children, they*
18 *were all much older than me. Their son's*
19 *name is Louis Brady. Louis was an employee*
20 *in the local area, he lived independently*
21 *outside of the Brady family home. We would*
22 *visit Louis occasionally for the day but*
23 *our initial relationship with him wasn't*
24 *close.*
25
26 *At some time during the mid-1990s Louis was*
27 *fired from his position at the workplace.*
28 *I wasn't told why, but I was told by Ruth*
29 *that "they're saying he's done things but*
30 *he hasn't done them". As a result Louis*
31 *moved back to the Brady family home. I*
32 *later learned that he was fired from his*
33 *role because he had had a relationship with*
34 *someone underage.*
35
36 *When Louis moved back to the house there*
37 *must have been some sort of red flag raised*
38 *with Children and Youth Services. Three*
39 *staff from Children and Youth Services*
40 *visited the house and had a conversation*
41 *with my sibling and I in the presence of*
42 *Ruth. They told us that Louis was moving*
43 *home and asked us how we felt about it.*
44 *They then asked us what we wanted to do. I*
45 *don't recall them telling us why Louis had*
46 *been fired from his role. Both my sibling*
47 *and I told them that we wanted to stay in*

1 *the home.*
2
3 *Up until this point Ruth and Allen provided*
4 *us with stability, warmth, food and other*
5 *things we didn't have in our own home. We*
6 *hadn't been told what had happened with*
7 *Louis and didn't understand the*
8 *implications or risk of him coming to live*
9 *in the house with us. We were children.*
10 *We should have been removed from the house*
11 *by Children and Youth Services, at least*
12 *until the allegation in relation to Louis*
13 *had been resolved.*
14
15 *I recall that Children and Family Services*
16 *told us that they would visit us regularly*
17 *after this, but they didn't.*
18
19 *In the late 90s, when I was aged less than*
20 *15 years old, Louis gained the friendship*
21 *and trust of my sibling and me. He would*
22 *always act cool around us, often going*
23 *against Ruth, allowing us to do things and*
24 *taking our side. Louis was just this cool*
25 *adult, that's how the relationship*
26 *developed. We liked him. Looking back*
27 *now, I can see that he was grooming us.*
28
29 *Louis would do things like wrestle me on*
30 *the ground in front of everyone and when he*
31 *did this I could feel his genitals pressing*
32 *against me. He would play with us, try to*
33 *get really close to us and kiss us. This*
34 *was the first stage of abuse and it got*
35 *worse from there.*
36
37 *My sibling and I shared a large room as our*
38 *bedroom. There was a partition between us*
39 *which separated our beds and gave us*
40 *privacy from each other. All of the other*
41 *bedrooms and living areas within the house*
42 *were elsewhere. This set up and location*
43 *of our room provided Louis the privacy to*
44 *come from the rest of the family and do*
45 *what he wanted.*
46
47 *He started to come to our room and sexually*

1 *abuse me before I went to sleep. I can't*
2 *recall exactly how many times this occurred*
3 *but it was quite a lot. I don't want to*
4 *provide any more detail of the sexual abuse*
5 *in this statement.*
6
7 *One night in the late 90s I woke up in the*
8 *middle of the night and I could feel*
9 *someone's presence. I looked for my*
10 *digital alarm clock and couldn't see it. I*
11 *then felt Louis unbuttoning the shirt of my*
12 *pyjamas. The top buttons were already*
13 *undone and I could feel him going for*
14 *another. I could smell alcohol on his*
15 *breath, I was terrified and remember my*
16 *heart beating really fast. I woke up,*
17 *Louis left. I don't remember why he left,*
18 *I just remember him walking out. I was in*
19 *early high school when this occurred, so*
20 *would have been less than 15 years old.*
21
22 *What happened that night was my breaking*
23 *point, I was so terrified and angry. I*
24 *didn't want him to do these things to me so*
25 *decided that I wouldn't speak to him. For*
26 *the week I completely ignored Louis. It*
27 *became this big joke across the house that*
28 *I was an immature child not talking to him.*
29 *Louis and Ruth were literally laughing at*
30 *me about it.*
31
32 *One morning around a week later I saw my*
33 *sibling play wrestling with Louis on the*
34 *ground. They knew I wasn't speaking to*
35 *Louis and that something was wrong so I*
36 *became really angry and upset with them for*
37 *playing with him. I said to them, "Stop,*
38 *you've got to stay away from him". They*
39 *asked me if something had happened and I*
40 *said yes. I didn't tell them everything*
41 *but told them what had happened a week*
42 *earlier. After this we made a pact to*
43 *never leave each other alone with him*
44 *again.*
45
46 *My sibling decided that they would take it*
47 *upon themselves to tell Ruth about what had*

1 *happened. They told me to go to school and*
2 *said that they would deal with it. After I*
3 *had been at school for a short time I was*
4 *told by one of the duty students that I*
5 *needed to go home. Our house was only a*
6 *short distance from the school so I was*
7 *able to walk back.*
8
9 *When I got back to the house Ruth asked me*
10 *what had happened. I told her what had*
11 *happened on the night Louis woke me and she*
12 *responded by saying, "Oh, is that all?"*
13
14 *I had two conversations with Ruth that day*
15 *where I told her what happened. The second*
16 *conversation occurred in the lounge room*
17 *and I told Ruth that Louis had touched me*
18 *on the vagina. She just laughed at me so I*
19 *ran to my room crying.*
20
21 *The third conversation occurred at the*
22 *dining table. On this occasion Allen was*
23 *in the kitchen and was able to hear what I*
24 *was saying. After I described the abuse*
25 *Allen said words to the effect of, "This*
26 *has happened too many times. It can't be a*
27 *coincidence, they must be telling the*
28 *truth".*
29
30 *Children and Youth Services came shortly*
31 *after this and took me from my home. I*
32 *assume Ruth and Allen had called them.*
33 *Before we left, I wasn't given a chance to*
34 *pack any of my things, they just took me.*
35 *I recall that around a week later Children*
36 *and Youth Services got Ruth to pack my*
37 *things and send them to me but she kept a*
38 *whole heap of my stuff. I went from having*
39 *things to not, as a result of Ruth*
40 *withholding my things after I had made*
41 *allegations against her son.*
42
43 *It was awful. Children and Youth Services*
44 *should have packed my things and taken them*
45 *with me. After leaving the Brady house I*
46 *went to live with another person. She was*
47 *a brave woman to take me in with everything*

1 *that was going on. I don't recall her*
2 *getting any support from Children and Youth*
3 *Services, nothing that I was privy to*
4 *anyway.*
5
6 *My sibling stayed with the Bradys for a*
7 *time after I left. I don't understand why,*
8 *but my understanding is that Children and*
9 *Youth Services let my sibling stay. I*
10 *don't recall where they moved to after they*
11 *left the Brady's house.*
12
13 *I believe that Ruth either knew what was*
14 *happening and ignored it or was in denial.*
15 *Allen worked nightshift so he was*
16 *completely oblivious. Prior to being*
17 *placed with the Bradys I had always been*
18 *paired up with another of my siblings. My*
19 *other siblings would often be placed*
20 *separately but that sibling and I were*
21 *always together. We were close and I was*
22 *heartbroken not to be placed with them this*
23 *time. I recall Ruth later saying that she*
24 *didn't want them there. There was only*
25 *ever female foster children in the house.*
26 *It seems odd to me that a parent would*
27 *request only female children in the home.*
28
29 *After I was removed from the Brady family I*
30 *believe that Children and Youth Services*
31 *continued to place female children in the*
32 *home. It is shocking to me that they*
33 *continued to put young girls in the house*
34 *despite my allegations and the clear risk*
35 *Louis posed.*
36
37 *After I was removed from the house,*
38 *Children and Youth Services encouraged me*
39 *to make a statement to the police. They*
40 *came and spoke to me at my house and I went*
41 *through what happened. I don't recall much*
42 *about this process but I remember Children*
43 *and Youth Services were present along with*
44 *some police officers. They told me that*
45 *even if I didn't want to proceed with the*
46 *charges it would be useful to have my*
47 *statement if I decided to proceed in the*

1 *future.*
2
3 *Initially I was going to go forward with*
4 *the police charges but a week or so later I*
5 *decided not to proceed. It was all too*
6 *hard and I was torn because of my affection*
7 *towards Ruth. I was missing her as a mum.*
8 *After I dropped the charges I arranged to*
9 *meet with Ruth through Children and Youth*
10 *Services but she never showed.*
11
12 *I was referred to the Sexual Assault*
13 *Support Service (SASS) and received some*
14 *formal counselling. I recall that the*
15 *building I went to was cold and dark and I*
16 *didn't feel comfortable. Because I didn't*
17 *feel comfortable, I didn't want to talk*
18 *about what happened. I'm not sure if the*
19 *barriers were due to the environment or*
20 *were existing internal barriers that I*
21 *already carried. I was so young and*
22 *vulnerable and I just didn't feel*
23 *comfortable. I also wanted to be cool and*
24 *not acknowledge that this sort of thing*
25 *happened to me.*
26
27 *Around the mid-2000s I was contacted by a*
28 *member of police or another representative*
29 *of the state who asked me if I wanted to be*
30 *involved in the court case against Louis*
31 *Brady. I was told that there were four or*
32 *five other girls making complaints against*
33 *Louis; this included a child who had spent*
34 *time with the Brady family before I did and*
35 *a girl who had also lived with the Brady*
36 *family. I was told that that person was*
37 *aware of my abuse so had alerted them to*
38 *it.*
39
40 *I provided a statement to the police, which*
41 *was awful. I went into the police station*
42 *to make my statement. Prior to making the*
43 *statement I had been told by someone that I*
44 *had to recall three separate incidences of*
45 *abuse for Louis to be charged with*
46 *maintaining a sexual relationship with me.*
47 *I went in to provide the statement with*

1 *this in mind.*
2
3 *When I recounted the first time I was*
4 *sexually abused by Louis the person taking*
5 *my statement said, "Oh, is that all it*
6 *was?" This has really stuck with me, I*
7 *felt like I'd been judged. While the first*
8 *incident I had spoken about was minor in*
9 *the scheme of what happened to me, it was*
10 *still significant and confronting for a*
11 *child to experience.*
12
13 *I went on to recall the other abuse that I*
14 *suffered. The process of taking the*
15 *statement, which was handwritten, took a*
16 *long time and the way it was done made me*
17 *feel like I was intruding on their time.*
18 *There needs to be a better way of victims'*
19 *statements to be recorded.*
20
21 *After making my statement to the police I*
22 *don't recall being offered any counselling*
23 *or support. I didn't have much to do with*
24 *the police after this.*
25
26 *Louis was charged with maintaining a sexual*
27 *relationship with a minor in relation to*
28 *his abuse of me. He was also charged with*
29 *offences relating to the abuse of other*
30 *girls. In the lead-up to the trial there*
31 *were two Crown prosecutors that I dealt*
32 *with: the first one I felt comfortable*
33 *with, he talked me through the process and*
34 *was familiar with my statement. I shared*
35 *intimate details with him and we developed*
36 *a good relationship.*
37
38 *Then the week before the trial it all*
39 *changed and a new prosecutor was appointed.*
40 *When this happened I felt like I had to*
41 *rehash all of my intimate information. It*
42 *was uncomfortable and re-traumatising. I*
43 *didn't feel supported. While I accept that*
44 *the prosecutors, have huge workloads, the*
45 *sudden change to someone I didn't know so*
46 *close to the commencement of the trial*
47 *really rattled me.*

1
2 *I recall going into the prosecutor's office*
3 *at some point having a statement put down*
4 *in front of me and being asked to read it.*
5 *The statement I was given wasn't mine, it*
6 *was a statement of another witness who had*
7 *been severely sexually abused from a very*
8 *young age. I only read a few lines but it*
9 *was in graphic detail and was harrowing to*
10 *read. What I read has stuck with me even*
11 *many years later.*
12
13 *When we realised I'd be given the wrong*
14 *statement the prosecutor didn't really say*
15 *anything, he just apologised and handed me*
16 *a copy of my statement.*
17
18 *I would have liked a bit more interaction*
19 *with the prosecutors in the lead-up to the*
20 *trial. They briefed me on the day about*
21 *how to act in court but it was a lot to*
22 *take in at once. The trial was the first*
23 *time I had faced my abuser so I was*
24 *petrified. It was almost impossible to*
25 *focus and retain information in that*
26 *situation. There needs to be someone to*
27 *support and guide victims as they go*
28 *through that process from beginning to end.*
29
30 *I gave evidence in court and found having*
31 *to relive my abuse so publicly very*
32 *traumatic. I didn't have much contact with*
33 *other victims as they wanted to keep our*
34 *stories separate. Ultimately we lost the*
35 *court case, I don't really know why.*
36
37 *Shortly after the trial was concluded the*
38 *prosecutor called me and left a message to*
39 *tell me the result. That was the last time*
40 *that I heard from them. I didn't receive*
41 *any follow-up to check how I was doing or*
42 *to see if I had any questions about the*
43 *decision. There was nothing from the*
44 *prosecutor and nothing from police. I was*
45 *shattered with the result, especially given*
46 *it had taken so much effort to go through*
47 *the process. I had always believed that my*

1 *abuser would be held accountable and go to*
2 *jail. This added to my trauma.*
3
4 *To not be offered any support afterwards*
5 *felt like I was being told, "Thanks for*
6 *your time, see you later". I don't know*
7 *what has happened to Louis and I don't know*
8 *where he lives. He tried to add me on*
9 *Instagram about three months ago. I was*
10 *sickened by the fact that he thought we*
11 *could be friends; it just re-affirms to me*
12 *that these people feel like they can get*
13 *away with anything.*
14
15 *I haven't accessed the National Redress*
16 *Scheme. I have thought about it but feel*
17 *like I don't want to get paid money for*
18 *something like this. I am who I am despite*
19 *what happened to me. I don't really want*
20 *to be paid for it. To me, it almost*
21 *dismisses what has happened. I want to be*
22 *part of the conversation and make change*
23 *rather than just be paid money and move on.*
24
25 *Children and Youth Services should have*
26 *done better. They had a clear red flag yet*
27 *they kept us in that home. In these*
28 *situations they should not be asking*
29 *children who don't understand risk what*
30 *they want. Children and Youth Services*
31 *needed to make the decision.*
32
33 *If there is any risk to a vulnerable child,*
34 *that child should be removed from the*
35 *environment. I accept that it would have*
36 *been traumatising for them to remove me and*
37 *my sibling from the home, but it would have*
38 *been far less traumatising than the abuse I*
39 *endured.*
40
41 *They had the opportunity to protect me, but*
42 *they didn't. They also failed to visit us*
43 *more frequently, which they said they*
44 *would. If they had have followed up I may*
45 *have disclosed the abuse earlier.*
46
47 *Another issue with Children and Youth*

1 *Services is the high turnover of staff.*
2 *There is no continuity for children in*
3 *care. It's difficult to build trust when*
4 *you are constantly speaking to different*
5 *people.*
6
7 *There needs to be more support provided to*
8 *victims through the court process. I*
9 *wasn't supported. The court process and*
10 *facing my abuser was almost as traumatising*
11 *as the abuse itself. It's a long process*
12 *which, for me, was drawn out over one or*
13 *two years. There needs to be a single*
14 *person that provides support throughout the*
15 *whole process from the time you make your*
16 *statement to the time the trial was*
17 *complete. I didn't have that and often*
18 *wouldn't know what was going on when there*
19 *were gaps in the process. The government*
20 *should be leading the way on this and*
21 *providing the best support available.*
22
23 *There should be support provided in schools*
24 *for children who are victims of abuse.*
25 *Children attend school every day and often*
26 *take these issues to school with them.*
27 *Teachers need to receive training so that*
28 *they are equipped to support children in*
29 *these situations.*
30
31 *I had teachers who I spoke to about Louis*
32 *but they weren't equipped to deal with the*
33 *sensitivity of it. All teachers need*
34 *specialist training and knowledge as*
35 *children place their trust in different*
36 *teachers. Staff with expert knowledge*
37 *could also be placed at schools to provide*
38 *a higher level of support.*
39
40 That's the statement of Faye.
41
42 PRESIDENT NEAVE: Thank you, Ms Rhodes, that was a very
43 moving statement. Yes, you can stand down now and we'll
44 call our next witness I think - oh no, morning tea. We'll
45 have a short break, sorry.
46
47 **SHORT ADJOURNMENT**

1
2 MS ELLYARD: Thank you, Commissioners, the next witness is
3 Ms Claire Lovell, I'll invite her into the witness box and
4 take the affirmation.
5
6 **<CLAIRE LOVELL, affirmed and examined: [11.05am]**
7
8 **<EXAMINATION BY MS ELLYARD:**
9
10 MS ELLYARD: Q. Thanks, Ms Lovell, feel free to take a
11 seat. My I ask you, please, your full name?
12 A. Yes. Claire Lovell.
13
14 Q. What's the present position that you hold?
15 A. I'm the Executive Director of Children and Family
16 Services.
17
18 Q. In the Department of Communities?
19 A. In the Department of Communities Tasmania, yes.
20
21 Q. How long have you held that role?
22 A. I've been the Executive Director since late last year,
23 2021, and prior to that - that's a newly-formed position;
24 prior to that I was the Director of Children and Family
25 Services from 2019.
26
27 Q. What was your career trajectory that led to you taking
28 up that role first as Director and then as Executive
29 Director?
30 A. I started working for the Child Safety Service, or as
31 it was then the Child Protection Service in 2004 as a Child
32 Safety worker. Since then I held positions as caseworker,
33 leadership positions since around 2006, including team
34 leader positions, clinical practice consultant and
35 educator; the manager of that team as the state's senior
36 Clinical Practice Manager. I also spent several years in
37 around 2013/14 in a policy area within the department,
38 still focusing on child safety policy.
39
40 Q. So, it sounds like you've held, on your way to the
41 present role, most of the roles in the hierarchy that sit
42 below you?
43 A. Some. Yes, some.
44
45 Q. And, given that you started as a Child Safety Officer,
46 do I take it that you have a background in social work or
47 in other form of Allied Health?

1 A. Yes, I hold a Bachelor of Arts degree. I graduated
2 from the University of Tasmania in 2001 majoring in
3 sociology, and at that time I was also a volunteer family
4 support worker working with parents with young children who
5 needed extra support.
6
7 Q. So, you studied in Tasmania and your professional
8 career has been in Tasmania?
9 A. That's correct, yeah.
10
11 Q. And overwhelmingly within the Child Safety Services
12 system?
13 A. Almost entirely, yes.
14
15 Q. Thank you. Now, you're here today in your capacity as
16 the Executive Director to answer some questions about
17 matters which are contained in one of the statements that
18 the Secretary, Mr Pervan, has made; in particular,
19 Commissioners, his statement in response to the request for
20 statement 23. Ms Lovell, that statement's not yours, but
21 do I take it that you've had the opportunity to become
22 aware of the contents of it?
23 A. Yes, that's correct.
24
25 Q. It's got a lot of attachments which perhaps you
26 haven't gone to in detail, but many of those attachments
27 are themselves documents that are generated from inside
28 Child Safety Services?
29 A. Some, yes.
30
31 Q. And if at any point I ask you a question that falls
32 outside the scope of your knowledge, please tell me.
33
34 Firstly, to set the scene for Child Safety Services
35 and where it sits in the broader framework of the
36 Department of Communities. You've mentioned that your role
37 is a recent role as an Executive Director, you were
38 previously a Director. Could you outline for us, please,
39 the executive structure of the Department of Communities,
40 who do you report to, who reports to you?
41 A. As Executive Director of Children and Family Services
42 I report to the Deputy Secretary of Children, Youth and
43 Families and they in turn report to the Secretary of
44 Communities Tasmania.
45
46 Q. Are there other reports to the Deputy Secretary other
47 than you?

1 A. Yes. The Director of, I think, Custodial Services.
2
3 Q. So the work of the children and families branch then
4 sits alongside the work of Custodial Youth Services?
5 A. It does.
6
7 Q. And the two Executive Directors report to the Deputy
8 Secretary for Children, Youth and Families?
9 A. The other is a Director, I'm an Executive Director of
10 my portfolio, and I'm also assisted by a Director.
11
12 Q. Thinking about what falls within your portfolio, we're
13 examining out-of-home care, but that's just one component
14 of what your role involves. Can you summarise for us your
15 areas of responsibility?
16 A. Yes, certainly. So, within my portfolio I am
17 responsible for the operations of the Advice & Referral
18 Line, so the manager of that service reports - reports to
19 the Director. I should start by saying, between the
20 Director and myself, we collectively support and supervise
21 a team of managers across the portfolio.
22
23 Q. Of course.
24 A. Because that's a new arrangement, we are adjusting as
25 we go so I'll try and describe those differences, but
26 together we're responsible for the operational direction
27 for those services. So, they include the Advice & Referral
28 Line, the Child Safety Service, the Intensive Family
29 Engagement Service, out-of-home care, adoptions, permanency
30 and after care support.
31
32 Q. Thank you. As I understand it, there's a degree of
33 overlap between parts of those services so that, for
34 example, thinking about out-of-home care which is our
35 focus, children in the out-of-home care component of your
36 portfolio will also be sitting in the Child Safety Services
37 component because they're subject to protective
38 intervention by the Secretary?
39 A. That's correct, yes.
40
41 Q. Can I turn then to ask you some general questions
42 about how out-of-home care operates in Tasmania.
43 Commissioners, for your purposes I'm starting at
44 paragraph 74 and following of Mr Pervan's statement, but
45 I'll ask Ms Lovell about these things, I'm sure she knows
46 the answers.
47

1 Firstly, to put it at a very high level of generality,
2 the out-of-home care system in Tasmania is funded by the
3 government, it's a publicly funded activity; is that right?
4 A. Yes.
5
6 Q. And it's partly provided as well by the government,
7 the government is itself a provider of out-of-home care
8 services?
9 A. Yes, it is.
10
11 Q. In other cases it contracts with non-governmental
12 organisations to provide for foster care?
13 A. Yes.
14
15 Q. Or other kinds of out-of-home care?
16 A. Yes, that's correct.
17
18 Q. And so, when we think about the out-of-home care
19 system, we are talking both about the frontline providers
20 of care which could include department providers and
21 non-governmental providers: yes?
22 A. Yes.
23
24 Q. But we're also talking about what I will term the
25 back-of-office functionality which is staff members within
26 Child Safety Services who work directly to facilitate
27 out-of-home care?
28 A. Yes.
29
30 Q. At paragraph 81 and following, Commissioners, in the
31 statement Mr Pervan gives some evidence about the
32 out-of-home care system. As I understand it, Ms Lovell,
33 the out-of-home care department of Child and Family
34 Services reports to you or perhaps through a Director to
35 you?
36 A. Yeah. So, the teams within Children and Family
37 Services who directly deliver support to Family-Based
38 Carers, they report to a statewide manager of out-of-home
39 care adoptions, permanency and after care support, and that
40 person reports directly to me.
41
42 Q. We understand from the information provided by
43 Mr Pervan, is that, there are a total of 23 departmental
44 officers who work in the out-of-home care component of
45 Child Safety Services?
46 A. Yes.
47

1 Q. Comprising 17 Child Safety Officers, three practice
2 leaders, two managers and a unit coordinator. Does that
3 match your understanding?
4 A. Yes.
5
6 Q. When we talk about the 17 Child Safety Officers,
7 they're Child Safety Officers working in out-of-home care
8 rather than in some other branch of Child Safety Services?
9 A. Yes, that's correct.
10
11 Q. As I understand it, some of these positions are new?
12 A. Yes. So, working alongside the statewide manager
13 there is an additional manager position which has been
14 recently created, and that position focuses on business
15 coordination; so, the way that we manage carers' approvals
16 and making sure that our data on households is correct, and
17 it's primarily focused on safety and compliance with
18 approval conditions.
19
20 Q. That business coordinator role's referred to at
21 paragraph 87 of Mr Pervan's statement. Is that a role
22 that's focused on those carers who are directly engaged by
23 the department as opposed to NGO providers, or is it both?
24 A. It's very early in its implementation, it's a
25 temporary position, so what we are doing at the moment is
26 making sure that the data that we hold is correct but also
27 working with the other providers to make sure that the data
28 that they have is input correctly into our system so that
29 we have the most complete picture possible around current
30 approved households.
31
32 Q. And when we talk about "data" can I ask you to unpack
33 a bit, what kind of data and information are we talking
34 about?
35 A. Yeah, so information about care households, so
36 Family-Based Care is stored in the Child Protection
37 Information System, which we refer to as CPIS. So,
38 household information would include who the carers are and
39 their information but also the children who are placed with
40 them. That's where we would store information around, so
41 case notes relating to the work of these out-of-home care
42 workers, the out-of-home care workers within Children and
43 Family Services, so that's where they store their records
44 associated with their responsibilities.
45
46 Q. Is the creation of this role the result of a view that
47 perhaps data quality or accuracy wasn't where the

1 department wanted it to be?
2 A. Certainly, yes, data quality, inaccuracy, but also our
3 responsibility to make sure that people who are caring for
4 children still comply and continue to comply with basic
5 approval requirements.
6
7 Q. Thank you. At paragraph 92 of Mr Pervan's statement
8 he provides some figures both about the number of children
9 in Tasmania who live in out-of-home care and the
10 proportions of those children who live in care provided by
11 non-governmental organisations or directly by the
12 government. As I understand his evidence, just over
13 70 per cent of children in out-of-home care live in
14 placements that are provided directly by the department; is
15 that right?
16 A. Yes, the department is the largest Family-Based Care
17 support provider.
18
19 Q. And the balance of the children is about 28 per cent
20 live in placements that are organised by non-governmental
21 organisations?
22 A. Yes, that's correct.
23
24 Q. Who have been contracted to provide those services by
25 the department?
26 A. Yes.
27
28 Q. Is the engagement and contracting of those
29 non-governmental organisations part of the work done in the
30 area of the department for which you are responsible?
31 A. It occurs within the division but not directly within
32 my portfolio.
33
34 Q. So, the people who do that work don't report to you?
35 A. There's only one person who does that work in Children
36 Youth and Families, the manager of strategic commissioning,
37 and that person also undertakes commissioning work for
38 other parts of the division, which can include custodial
39 services, also Youth Justice - which, I should add, has
40 recently been added to my portfolio, but also to new
41 strategic project work, yep.
42
43 Q. That sounds like they'll be very busy?
44 A. Yes.
45
46 COMMISSIONER BROMFIELD: Q. So that one person who's
47 doing the strategic commissioning role, do they also have

1 then the oversight role in terms of ensuring that their
2 non-government providers are complying with contractual
3 obligations, that they're fulfilling everything that they
4 said they would do in terms of how they would provide care?
5 A. No, not entirely. There's very, very limited
6 oversight that can occur by that one person.
7
8 Q. Who does it?
9
10 PRESIDENT NEAVE: Sorry, have you finished your question?
11
12 COMMISSIONER BROMFIELD: No.
13
14 Q. That's not surprising for one role doing strategic
15 commissioning for a department. Is there someone who's
16 charged then with the oversight of the contractual
17 obligations and, I guess, the quality assurance?
18 A. Yeah, that responsibility is currently spread to
19 different positions in different ways. So, some of that
20 oversight occurs at the child level, through the Child
21 Safety Service, then we have other processes such as, the
22 Australian Childhood Foundation are contracted to review
23 the care provided to children in residential care settings.
24 So our division receives reports in relation to that,
25 myself and the Deputy Secretary receive that information,
26 but some of that information also goes to the Child Safety
27 Service at the child level.
28
29 We also have the non-government providers, they're
30 required to provide monthly reports which are also
31 reviewed.
32
33 COMMISSIONER BROMFIELD: Thank you.
34
35 PRESIDENT NEAVE: Q. Sorry, I have a follow up with that
36 one too. So, the manager of strategic commissioning, I
37 think you also said had some responsibility in the Youth
38 Justice area as well?
39 A. Yeah, yep.
40
41 Q. So, they're involved in the strategic commissioning
42 role and the oversight of - the oversight of Youth Justice?
43 A. Not the oversight. So, things like developing and
44 revising funding agreements for contracted services, so
45 it's not just limited to out-of-home care services; that
46 can include the services used by Youth Justice which are
47 more like targeted youth support services.

1
2 PRESIDENT NEAVE: Thank you.
3
4 MS ELLYARD: Q. We've made the point, Ms Lovell, that
5 the out-of-home care workers within Child Safety Services
6 form an out-of-home care team which works alongside other
7 teams of Child Safety support officers who perform other
8 functions in either assessment or case management. Could
9 you summarise for us, please, the Structure of Child Safety
10 Services of which the out-of-home care team is a part?
11 A. Yeah. So, our out-of-home care teams, there are three
12 teams around the state - south, north, west and north. We
13 also have the equivalent for the Child Safety Service, so
14 they're co-located with the general Child Safety Service
15 staff, usually the response and case management teams who
16 work with children who are on orders but also in the
17 assessment and family preservation stage.
18
19 Q. You've mentioned a number of things there and I just
20 want to unpack them. So, you've mentioned case management:
21 that's a team that work with children who are on orders
22 that have placed them in the custody and/or the
23 guardianship of the Secretary?
24 A. Yeah, multiple teams within each service.
25
26 Q. There's also teams who carry out initial assessment
27 work where referrals are received through to the Child
28 Safety Services from the Advice & Referral Line?
29 A. Yes.
30
31 Q. And, as part of that work there are Child Safety
32 Officers who work with children and families who may have
33 been referred but who ultimately won't go on to be part of
34 the statutory system?
35 A. Yes.
36
37 Q. At paragraph 37 of Mr Pervan's statement he makes
38 reference to the practice guidance in relation to - I'm
39 sorry, it's attachment 37 to the statement of Mr Pervan -
40 the six domains against which action is to be taken, or the
41 six domains within which children are entitled to feel safe
42 and protected. I'm sure you know them, but just for me to
43 summarise them. The six domains, as I understand, are:
44 being loved and safety, being healthy, participation,
45 having material basics met, learning, and having a positive
46 sense of culture and identity. Is that right?
47 A. Yes.

1
2 Q. What's the origin of those six domains and what's the
3 way in which they inform, in particular, the way in which
4 the out-of-home care system is run?
5 A. So, those are the six domains of the Child and Youth
6 Wellbeing Framework; that framework was developed,
7 I believe, around 2018, or possibly developed before then
8 but that's when we began to implement it. It's been well
9 implemented within the Advice & Referral Line and guides
10 their work, and gradually since that time it's also been
11 implemented in various ways across the Child Safety Service
12 and that work is continuing. It's also used within other
13 agencies, including the Department of Education and
14 non-government service providers as well, so it gives us
15 one framework for understanding the holistic needs of
16 children and young people but also their families.
17
18 So, the Child and Youth Wellbeing Framework works well
19 for us alongside the Social Wellbeing Model where we're
20 gradually - we're gradually changing the way we view
21 children and their safety and wellbeing as something that
22 is just them, to something - how can I explain this well?
23 Let me find my words. The premise of the Social Wellbeing
24 Model is that we can't look after children and young people
25 and respond to their wellbeing needs without responding to
26 the wellbeing needs of the adults who care for them. So,
27 that can be their natural family or their care family, but
28 we need to be responding to the needs of both
29 simultaneously.
30
31 Q. And that's a transition from what, as I understand it,
32 was a previous model where the child was perhaps viewed
33 somewhat in isolation from their environment?
34 A. Yes, it's also known as a Child Rescue Model where
35 focus solely on the protection of children rather than
36 understanding a child's needs in the context of the family
37 who are ultimately responsible for caring for them.
38
39 Q. And not to suggest at all that there's anything wrong
40 with a focus on child wellbeing, but child protection is a
41 well understood concept which recognises that there are
42 circumstances where children do need to be protected. I
43 wonder, can you speak to the way in which these two issues
44 might potentially be held - a bit in tension - a focus on
45 wellbeing on the one hand and a focus on potentially
46 protecting on the other?
47

1 I ask the question, Ms Lovell, because the
2 Commission's heard some feedback about the extent to which
3 the change of language might have been accompanied by a
4 change in risk assessment processes and a change in the way
5 statutory intervention occurs.
6 A. Maybe it's more helpful to speak about safety rather
7 than protection, but safety is certainly one very important
8 element of the wellbeing framework: it hasn't been lost and
9 it never will be lost. But being loved and safe is as
10 important as the other wellbeing domains. To focus on one
11 to the exclusion of others doesn't serve children or
12 families well.
13
14 Q. So the move to the wellbeing model, I take it, isn't
15 accompanied by any changing of the level at which statutory
16 intervention might be contemplated for a child?
17 A. No, not the level of statutory intervention, but I
18 think the way that we respond to families is changing.
19
20 Prior to 2018 when the Advice & Referral Line came on
21 board it was a different model, it was a different
22 approach. I guess even though the mantra has always been
23 that Child Safety is everyone's responsibility, it actually
24 wasn't. We had mandatory reporting which meant that anyone
25 with a concern for children, they had an obligation to
26 report that which was fine, but there was less emphasis on
27 their other responsibilities/capabilities around how they
28 could also keep children safe and well.
29
30 Q. So, would I be right in understanding that what you're
31 identifying there is perhaps a greater - a model which
32 contemplates a greater sharing of responsibility for
33 children's wellbeing amongst the various community or
34 governmental parts that interact with the child rather than
35 it sitting solely with Child Safety Services?
36 A. Child Safety Service can't alone keep every child safe
37 and attend to every domain of wellbeing for every child in
38 Tasmania; that's just not possible. I know that there is a
39 belief or some frustration by many professionals in the
40 community - some professionals in the community - that they
41 experience pushback. Pushback is not what the Advice
42 & Referral Line or the Child Safety Service are striving
43 for: we are trying to build capacity in the community to
44 respond to the safety and wellbeing needs of children. So,
45 building capacity can be done through providing supports,
46 advice, education, resources, those types of things. I
47 guess we want to empower every person in the community to

1 do what they can to keep children safe and well.
2
3 Accepted, there are some cases where that's not going
4 to be possible and statutory intervention is absolutely
5 necessary. They're the children where referral is made
6 through the Child Safety Service for further involvement,
7 but even there our response is not to take over, it is
8 still to share that responsibility as much as we can, to
9 involve other professionals and to involve informal
10 networks for children so that they have a solid network
11 around them who can respond to their needs; it still
12 acknowledges the Child Safety Service isn't the only
13 answer.
14
15 Q. The Commission's heard, perhaps picking up on
16 something you said then, Ms Lovell, of cases where people
17 describe placing a call to the Advice & Referral Line to
18 raise what they regard as a safety issue relating to a
19 child and being asked in response, "Well, what have you
20 done about it?", and experiencing that as, to use your
21 word, a pushback when they understood that they were
22 handing it over to the experts.
23
24 Perhaps it's a communication issue, but it does seem
25 that they might be right, that from time to time they're
26 being asked to take action themselves or being invited to
27 take action themselves rather than just handing it on?
28 A. And I think that the wording that you used there is
29 important because, if people think that they're handing it
30 over to the Child Safety Service, then I think that's where
31 there can be a misunderstanding and some frustration
32 because, although the Child Safety Service can take a lead
33 in particular issues, responding to particular issues, you
34 can't hand a child over; the child still exists, the child
35 still has wellbeing needs and we rely on the professions
36 and the informal networks around a child to continue on
37 playing their part.
38
39 One thing that is different is that the Advice
40 & Referral Line is no longer what Child Safety intake was,
41 which is a passive receiver of reports and information and
42 allegations. The new process is far more interactive. The
43 Advice & Referral Line prefers phone calls for that reason
44 so that they can actually interact with callers and that
45 can be so that we can really dig for detail so that we can
46 really fully understand what's going on for families, so we
47 can understand the complicating factors that we're dealing

1 with so that we can understand their strengths, so that we
2 can understand what needs they have that have been met well
3 and needs that remain unmet, and the reason for that is so
4 that we can make - we can take the right action, we can
5 make the right referrals that are actually going to be
6 helpful for them.
7
8 So, the Advice & Referral Line seeks to assist
9 families rather than just receiving information, screening
10 that information to see whether it meets a threshold for
11 the Child Safety Service. This is what the old intake did,
12 it really was screening to see whether something met a
13 threshold; if it didn't meet the threshold the response was
14 closure. But for the family it didn't meet their need;
15 that left them potentially with no resolution to the issues
16 that they were facing, so those issues were left to recur
17 and exacerbate, often to the point where - well, certainly
18 to the point where the Child Safety Service received
19 multiple notifications and the situation was so dire then
20 that statutory intervention, often in the form of removal,
21 was required. That's also known as "system churn"; it also
22 leads to extreme cumulative harm for children.
23
24 It was far from ideal. I think that we have taken a
25 really positive and brave step in saying that we - we need
26 to do better by children and families, we need to
27 understand and respond to their needs. This is the public
28 health approach that we're striving to integrate. It's
29 been a hard push.
30
31 Q. So, I think what you're identifying there, Ms Lovell,
32 and I'm not doing justice when I paraphrase it, is that,
33 whereas perhaps under the old model there was a kind of a
34 binary response if you rang the intake line: it was either
35 accepted or it was closed. Now, the cases that might
36 previously have been closed have the opportunity to receive
37 assessment or supports or referrals of different kinds that
38 will meet the families' and the children's needs where
39 those needs fall under the level of statutory intervention?
40 A. That's correct.
41
42 Q. A word that we haven't used yet in relation to this
43 but I think it's what you're talking about when you talk
44 about meeting the threshold for intervention is the concept
45 of risk; of course, the statutory criteria for intervention
46 in a child's life relates to risk. Has the way in which
47 the department approaches the concept of risk changed as

1 part of this movement to a wellbeing framework?
2 A. I don't think the department's concept of risk has
3 changed, but I think we're becoming more sophisticated in
4 the way that we manage risks, so really trying to
5 understand what that risk is and who is best placed to help
6 the family to respond to that. So, just because there are
7 risks present for a child doesn't mean that that
8 automatically needs to come through to the Child Safety
9 Service because some of those risks and many of those risks
10 don't relate to child abuse; they relate to families with
11 unmet needs and children who are experiencing enormous
12 challenges, challenges with their mental health, for
13 example; families struggling to get the support that they
14 need to respond to their child's disability issues, those
15 are really complex needs. Those families don't necessarily
16 need the investigation approach used by the Child Safety
17 Service; they're not abusing their children, they're doing
18 their best but they need the support of multiple services
19 in our community.
20
21 Q. And this, of course, goes to that part of the
22 definition of "risk" that talks about parents being willing
23 and able or unwilling and unable to keep their child safe,
24 and what you're identifying is that there are a cohort of
25 parents who might be willing, potentially not able but able
26 with supports, and those are parents whose children
27 shouldn't enter the statutory system, they can be protected
28 outside of it?
29 A. That's correct, yes. Another example are matters
30 where there has been abuse of a child but where one parent
31 is willing and able to keep their child safe and they may
32 be supported through the Family Law Court to be able to do
33 that. That doesn't need to come through to the Child
34 Safety Service necessarily for statutory intervention
35 because there's already someone taking the right action and
36 the Family Law Court is an appropriate avenue for
37 supporting those parents who are willing and able to
38 protect their child.
39
40 Q. Thank you. I want to turn then to trace the pathway
41 that a child will take to end up in the out-of-home care
42 system. Commissioners, paragraphs 97 and following of
43 Mr Pervan's statement covers this.
44
45 Firstly, as I understand the evidence, Ms Lovell, a
46 child will reach the out-of-home care system through, if we
47 think about the present position, firstly being the subject

1 of a referral or a wellbeing concern made to the Advice
2 & Referral Line which finds its way to Child Safety
3 Services?
4 A. Yes.
5
6 Q. There will next be ordinarily an assessment and
7 perhaps a period of time during which an investigation is
8 undertaken?
9 A. Yes.
10
11 Q. It's made clear in Mr Pervan's statement that the
12 removal of a child from his or her family is the option of
13 last resort?
14 A. Yes.
15
16 Q. And so, a child who ends up in out-of-home care would
17 expect to have had at least some period of time where Child
18 Safety Services sought to investigate whether the child
19 could be supported to remain at home perhaps using the
20 kinds of supports that you've just been discussing?
21 A. In general there will be some cases, though, where all
22 of that is fast-tracked. So, in circumstances where the
23 child is at immediate risk, Advice & Referral Line can make
24 an immediate decision and on the same day that matter can
25 come through to the Child Safety Service; on the same day
26 we're working alongside Tasmania Police, and on the same
27 day that child may enter care as a result of what's
28 happened or --
29
30 Q. So sometimes it'll happen very fast but it'll happen
31 because an assessment, albeit at sometimes a very speedy
32 assessment, identifies that the last resort option is the
33 option that needs to be taken?
34 A. That's right, that's a response to immediate risk.
35
36 Q. Mr Pervan describes in his statement the process by
37 which - and perhaps leaving aside those extreme urgent
38 cases - the process by which decisions are made to seek a
39 court order for a child and the way in which there's
40 internal consultation within the department about that
41 process; can you explain that process to us, please?
42 A. Yes, so we have multiple family preservation attempts
43 and some really positive outcomes within the Child Safety
44 Service. So, the Child Safety Service doesn't just do
45 assessment and case management, it's not that simple. So,
46 from the beginning of the involvement of the Child Safety
47 Service they're working with families to understand the

1 parents' willingness and capacity to resolve risk issues
2 which are present for the child; they're also working with
3 other networks of people who can also be part of a safety
4 plan around that.
5
6 So, we continue on with those efforts, that may be
7 through the Intensive Family Engagement Service or it might
8 be within the Child Safety Service directly. If we reach a
9 point where that is not working because the parent is
10 demonstrating that they're not willing or not able to
11 engage with that process and the risk remains or the risk
12 is actually increasing for the child, it's at that point
13 that we will need to apply for legal orders under the
14 Children, Young Persons and Their Families Act.
15
16 Q. And there's an internal committee, as I understand it,
17 that is involved in the decision-making about whether or
18 not that point for court intervention has been reached?
19 A. Yes, there's a court application advisory group and
20 that comprises senior practitioners and managers from that
21 local Child Safety Service.
22
23 Q. And so, thinking again about a child whose trajectory
24 has brought them into the out-of-home care system, that
25 child will have been the subject of the processes that
26 you've described, an application to the court and an order
27 made by the court, and ultimately for children who remain
28 in out-of-home care for any length of time, most likely an
29 order placing them under the guardianship of the Secretary?
30 A. Yes.
31
32 Q. And then simultaneously with that court process, as I
33 understand it, an assessment is being made of where the
34 appropriate placement for the child will be?
35 A. Yes.
36
37 Q. As I understand it, that's a process as described by
38 Mr Pervan that involves a number of different bodies and
39 consultation between both government and non-governmental
40 providers of foster care?
41 A. Yeah.
42
43 Q. Can you explain that process to us?
44 A. So, the first thing that happens when a child needs to
45 enter care or even before a child needs to enter care the
46 Child Safety Service are actively seeking family, extended
47 family for the child or kin who can provide that care, so

1 that's the first option.
2
3 If there are no kin that can be identified, that are
4 willing and able to provide care, then we next look to
5 foster care. So, the out-of-home care teams within each
6 service are involved in both of those things, so they
7 support the assessment of kinship carers, but they also
8 support - they receive requests for placement with foster
9 carers and they progress that by reaching out to the
10 non-government sector to see which provider is able to
11 accept the placement, and they also look to our own foster
12 carers.
13
14 Q. You mentioned that the first option to be considered
15 if a child couldn't live with their immediate family would
16 be to look for a family placement or what you would call a
17 kinship placement. What's the assessment process for
18 kinship placements? There's lots of evidence in
19 Mr Pervan's statement about assessments and training for
20 arm's-length carers, but what's the process for kinship
21 carers?
22 A. Yes, so that's a three-part process. So, the first
23 part, keeping in mind that kinship placements are often
24 rapidly required on the same day or potentially even during
25 the night if it's an after-hours matter, so the first stage
26 is very brief; it's screening to make sure that the person
27 is willing, able, and that they're a safe person. Then the
28 Part B is more comprehensive and the Part C more
29 comprehensive again.
30
31 So, the first part, the Part A tends to be the Child
32 Safety Officer, often in the response team or an
33 after-hours worker. But then the support of out-of-home
34 care comes in to complete Parts B and C which is a more
35 comprehensive assessment; it's really looking at the needs
36 of that child and that carer, whether or not it's a vital
37 placement, but also how we need to support them so that
38 that's a success.
39
40 Q. I can imagine that if the question is, will this child
41 be safe with their aunt until Monday morning when court
42 opens, that's one thing, and the suitability of that carer
43 might be very foundational about appropriate accommodation
44 and things of that kind. But longer term what's the
45 assessment that's done of the proposed kinship carer to
46 satisfy the department that they are an appropriate person
47 to take on care of a child perhaps on behalf of the

1 Secretary?
2 A. So certainly there's safety screening, so as well as
3 having to hold the current Working with Vulnerable People
4 registration, there's National Police Checks undertaken,
5 and reference checks to make sure that they're safe people.
6 We can also refer to our own Child Safety information
7 systems, both systems, to see what history they have; not
8 necessarily looking to screen people out but to fully
9 understand any issues that they have experienced and how
10 that might impact on their current and future care.
11
12 Q. Are kinship carers expected to undergo the same
13 training programs that foster carers are required to
14 undergo?
15 A. No, they're not, no.
16
17 Q. Are you able to speak to the reason for that different
18 approach?
19 A. Yes. I'm not sure that that is the right approach,
20 I'll start by saying. I think that kinship carers do also
21 need to have - and I also don't know that "training" is the
22 right word - they need to have the understanding of issues
23 that are likely to present for the child and for them in
24 being able to care for the child. So, I don't --
25
26 PRESIDENT NEAVE: Q. Just to interrupt there. One
27 question: you talked about the assessment that's done by
28 the kinship carer, what about assessment for other members
29 of the household?
30 A. So the other members of the household, the same
31 applies that --
32
33 Q. What, they have a police check, for example, or
34 they're not required to have a Working with Vulnerable
35 People registration check, are they?
36 A. All members of the household over the age of 16 are
37 required to have the Working with Vulnerable People
38 registration.
39
40 Q. Right, and how does the department or the contracted
41 provider know about changes in the household? Are they
42 required to notify about changes in the household, so a
43 member of the family who wasn't there comes back, for
44 example?
45 A. Yes. So, carers are required to notify us of changes
46 to their household, but also when our staff undertake
47 reviews they will be asking that question around not only

1 has the composition of your household changed but who else
2 frequently visits the home, who else is the child
3 frequently interacting with.
4
5 PRESIDENT NEAVE: Thank you.
6
7 COMMISSIONER BROMFIELD: Q. While we've interrupted. I
8 was just wondering if you could actually outline, in the
9 Part A and the Part B screening, Part A, what are the basic
10 checks that you do do for the immediate placement?
11 A. Never having - or not having completed one myself
12 since, probably 2006 perhaps, I'm not familiar with the
13 exact forms. I know that they are annexed to Secretary
14 Pervan's statement. What I do know is that they are very
15 basic checks for Part A, so I think that that can actually
16 be as basic as checking with Tasmania Police in the middle
17 of the night, for example, on an after-hours job to see
18 whether this person, whether there's any history of
19 offending or other intel which would indicate that this
20 person is unsafe. Then I know that the very next things
21 that we have to do, the next business day if they haven't
22 already got a Working with Vulnerable People Check, is to
23 apply for that, and also to complete the paperwork for the
24 National Criminal History Check.
25
26 Q. Would you check the departmental records at the same
27 time as you're checking the TasPol records in Part A, would
28 that be the next business day?
29 A. Yeah, I imagine it would be a fairly superficial look
30 to satisfy Part A, so having a look at the summary of
31 history, but I think as we get into Parts B and C it would
32 be a far more in-depth look at anything that we have on
33 file and what that actually means for this family and this
34 child.
35
36 PRESIDENT NEAVE: Q. Do you have any data on the time
37 that it takes to go through the second part of the check?
38 So, a child is placed with their aunt overnight, then there
39 would have to be - if the proposition was that the child
40 was going to stay there, that there would then have to be
41 some other form of checking, the more detailed check you're
42 talking about. Do you have any data on how long those
43 processes take between moving the child from - possibly
44 moving the child from the emergency situation to staying
45 permanently with the family or for a period of time with
46 the family?
47

1 COMMISSIONER BROMFIELD: Q. To process Part A to Part C
2 to complete the assessment, do you have a timeframe, a KPI
3 around that?
4 A. No, I don't think there is a timeframe - well, I may
5 be wrong, I don't believe there is a KPI, I believe that it
6 should be done as soon as possible. I haven't heard of any
7 concerns about those timeframes. I have heard that there
8 is sometimes - there certainly is sometimes a dispute
9 around the appropriateness of kinship placements. That can
10 be a really difficult issue to navigate because, as well as
11 needing to ensure that the children are safe and they're
12 stable wherever they're placed, we also have principles
13 that we're applying with regard to sibling placements,
14 keeping children with their family and community in general
15 and then the Aboriginal Child Placement Principle. So,
16 it's very hard to have a policy decision that, if a family
17 looks like this it's a no; if a family looks like this,
18 it's a yes. It's not that simple, it has to be made on a
19 case-by-case basis taking into account the details specific
20 to that child and that family.
21
22 COMMISSIONER BROMFIELD: Thank you.
23
24 PRESIDENT NEAVE: Thank you.
25
26 MS ELLYARD: Q. Just one further question on this topic
27 of kinship placements, Ms Lovell. As I understand it and
28 as your evidence is and perhaps consistent with the Act, if
29 a child can't live with their immediate family the
30 preference would be that they remain with extended family
31 or otherwise connected to their culture or community, but I
32 take it that sometimes it's not a binary thing of, you
33 can't do that and therefore you move on to the foster care
34 option. There might be situations where the question is,
35 having regard to the needs of this child, what's the best
36 option? There's the foster carer option and there's a
37 family option and they need to be weighed and a decision
38 made about what will be best; is that right?
39 A. Yes, sometimes those two options are compared and
40 there needs to be a decision about what's best.
41
42 Q. Thinking particularly about the Aboriginal Placement
43 Principle which you mentioned. Mr Pervan gives some
44 evidence about this at paragraph 111 and following of his
45 statement and the Commission has received some evidence
46 about differing perspectives about the extent to which that
47 placement principle is given meaningful effect in the

1 decisions that are made about the placement of children.
2
3 From your perspective are there any barriers to the
4 Aboriginal Placement Principle being able to be given full
5 effect in Tasmania and, if so, what are they?
6 A. There are some barriers. I don't think that we apply
7 the principle as well as we could; some of that, some of
8 the reasons for that are practical reasons, but some of
9 them are our own maturity as a service in the way that we
10 respond to the needs of Aboriginal children. I think that
11 there's a lot that we can do, even - I think there's a lot
12 more that we can do from the very beginning of our
13 involvement with Aboriginal children starting from the
14 Advice & Referral Line, to understand who their networks
15 are, to reach out to their community members, to actively
16 involve them in planning and decision-making.
17
18 It's not good enough to apply the principle by
19 tokenistically asking at the time of placement of an
20 Aboriginal organisation, "Do you have any carers?", because
21 the Aboriginal organisations aren't Family-Based Care
22 providers so the answer's likely to be "no". Unless the
23 child is able to be placed with kin, in which case we can -
24 you know, the Aboriginal Child Placement Principle is
25 applied, but I think in general we need to be making active
26 efforts at the earliest point which is as soon as we
27 receive that first contact.
28
29 We do have the Aboriginal liaison officers in the
30 Advice & Referral Line now which is incredibly helpful. I
31 think that, once a family is transferred through to the
32 Child Safety Service we still have a long way to go in that
33 really meaningful engagement in planning and
34 decision-making.
35
36 Q. Some of the evidence that the Commission is going to
37 hear later this week from another jurisdiction deals with
38 the fact that the placement principle - I mean, it's called
39 the placement principle, but it's not just about where you
40 decide to place a child after the decision's already been
41 made to remove them, it's actually a principle that's meant
42 to be infused through the entirety of Child Safety's
43 contact with the family; it sounds like you would agree
44 with that?
45 A. I thoroughly agree with that, yes. We do use the
46 language "active efforts" in Children and Family Services
47 because I think that does embrace that need to be actively

1 making efforts at every point, not just to consult with
2 Aboriginal organisations, but to let the Aboriginal
3 community step in and take the lead to the fullest extent
4 possible.
5
6 Q. Thank you. Can I turn then to some questions about
7 who are the people who will be sitting around or working
8 around a child who is placed in out-of-home care. Firstly,
9 as I think we've already discussed, any child who is in
10 out-of-home care will be part of the caseload of a Child
11 Safety Officer; is that right?
12 A. Ideally, if they have a Child Safety Officer. If
13 their Child Safety Officer is on leave or if in fact that
14 position becomes vacant, it tends to be the Practice Leader
15 for that team that takes responsibility. But, yes, the
16 children are allocated to a team.
17
18 Q. I see, and then it's a matter for each team how they
19 allocate children amongst the available staff?
20 A. That's correct, yeah.
21
22 Q. So, in addition to the Child Safety Officer that the
23 child will have by virtue of being on an order, will the
24 child also have a case manager inside the out-of-home care
25 team?
26 A. No, they don't have a case manager in the out-of-home
27 care team. The out-of-home care teams provide support to a
28 household, so they're primarily working with the carers
29 rather than the child.
30
31 Q. When you say they're working with the carers, does
32 that mean they're working with the carers when the carers
33 are directly engaged by the state as opposed to
34 non-governmental providers?
35 A. So, each of the non-government providers will support
36 the carers that are - Family-Based Carers are all
37 volunteers so it's hard to describe how they're engaged,
38 but yes, they each provide support to the carers who are
39 engaged with their respective service.
40
41 Q. So, the 72 per cent of children who are in a placement
42 organised directly by Child Safety Services, out-of-home
43 care section, will be living in a home where those carers
44 have an allocated caseworker from inside the out-of-home
45 care team?
46 A. The household, yes. The carers have an allocated
47 worker, yes.

1
2 Q. In the case of the 28 per cent of children who are
3 living in foster placements or out-of-home care placements
4 organised by a non-government organisation, that function
5 of who supports the carers will be fulfilled by the
6 non-government organisation?
7 A. That's correct, yes.
8
9 Q. Once a child's placed in out-of-home care then, what's
10 the role of the Child Safety Officer? What's the role that
11 they are doing? I can imagine it's one thing for a child
12 who's still living at home or who is being actively
13 monitored whilst they go through the assessment process,
14 but once a child is perhaps the subject of a long-term
15 placement in out-of-home care, is there a continuing role
16 for their Child Safety Officer and, if so, what is it?
17 A. So children where there is an interim Care and
18 Protection Order or where there's a likelihood that they're
19 going to remain in care beyond the assessment phase, they
20 are transferred through to case management teams. So, case
21 management teams, the child will be allocated to one of the
22 Child Safety Officers within that team. They take
23 responsibility for managing the Care Team for that child,
24 which includes developing their case and care plan and
25 holding care team meetings within the child's network;
26 that's their case coordination role. They're also
27 responsible for a lot of decisions for the child, the
28 day-to-day decisions and plan - I guess, the ad hoc issues
29 that come up every day and every week for children that
30 aren't included in detail in the case and care plan are the
31 things that they need to be responsive to.
32
33 They're also responsible for visiting children, also
34 in many cases still working with families, whether that be
35 through supporting contact arrangements or supporting
36 families through restoration processes.
37
38 Q. So, would it be fair to say that the Child Safety
39 Officer is the parent representative where the parent is
40 the Secretary; they're the person through which the
41 Secretary is exercising, at the moment, his parental
42 obligations towards the child?
43 A. Yes, that's correct.
44
45 Q. But they do so in part by coordinating a Care Team?
46 A. Yes.
47

1 Q. Can you tell us - and we understand from Mr Pervan's
2 statement that every child in out-of-home care will have a
3 Care Team and meetings that are convened for the purposes
4 of establishing and reviewing a care plan. Who, other than
5 the Child Safety Officer, will be in the Care Team for a
6 child in out-of-home care?
7 A. I should clarify that we're working toward every child
8 having a Care Team.
9
10 Q. Okay?
11 A. So, this is a relatively new approach, and it's an
12 approach that we have attempted to implement during the
13 COVID outbreak as well, so we're experiencing more staff
14 vacancies than usual, but we are gradually building up to
15 every child having a well-functioning Care Team.
16
17 So, a Care Team at its best will include the child,
18 first and foremost, child or young person; their Child
19 Safety Officer and other representatives from the Child
20 Safety Service if necessary. Also professionals, so people
21 from the Education Department. If they've got a particular
22 health professional, if they've got a counsellor. Anyone,
23 I guess, who has a responsibility in attending to the
24 domains of wellbeing formally is invited to be part of the
25 Care Team.
26
27 Also the child's carer is really important in the Care
28 Team; they're the person that spends the most time with the
29 child and provides their day-to-day care, so it really is
30 essential that carers attend. Ideally, we also have
31 parents attending if that's possible, if they're willing
32 and able to do so, and also other informal networks and
33 supports for the child.
34
35 Q. You said that you're working towards every child
36 having a Care Team. Thinking about the perhaps around
37 1,000 children who are in out-of-home care right now, what
38 percentage of them right now have a Care Team?
39 A. I don't have that data in front of me at the moment,
40 but I would be very cautious in putting a number to it
41 because, as I described, at best that's what the Care Team
42 will look like. But we have some care teams where
43 technically you can tick the box and say that the child has
44 a Care Team, but it's very limited. It might just be the
45 Child Safety Officer and the person from the school, and
46 maybe one other - and maybe the carer, something like that;
47 it's very limited.

1
2 So, we're working on building them so that they do
3 have all the people, but we're also working on building the
4 plans to reflect the wellbeing domains and making sure that
5 what that Care Team are working toward is achieving the
6 goals for the child as informed by the child. So, some
7 care teams, they have a group of people, but their scope is
8 still quite narrow and they're looking at day-to-day issues
9 rather than the long-term planning that children need.
10
11 So the two things that we're working toward - well,
12 two of the main things that we're toward with care teams is
13 making sure that the right people are involved and making
14 sure that the plan has a broad enough scope so that it's
15 actually an active way of working toward achieving goals
16 for children.
17
18 Another important thing that we're working toward with
19 care teams is power sharing. So, before Care Teams, it
20 really was that the Child Safety Officer was the go-to
21 person that held the responsibility for making all the
22 decisions and determining what the plan was for the child.
23 Some of those things, obviously, would be at a higher
24 delegation, so the Child Safety Officer needs the
25 permission of a Practice Leader or manager to make those
26 decisions, but the power was held within the Child Safety
27 Service. So, what the Care Team approach seeks to do is
28 share that, recognising that there is a range of expertise
29 around how best to achieve goals and there's a range of
30 support that the child is going to need; it doesn't all sit
31 with the Child Safety Service.
32
33 COMMISSIONER BENJAMIN: Q. Ms Lovell, just to be clear
34 in my mind. Is it 72 per cent or 100 per cent of the
35 1,000 children we're talking about at the moment has a
36 Child Safety Officer? Is it 100 per cent or just
37 72 per cent? And I'm talking about the ones - I think you
38 said 72 per cent of the children are in care through the
39 state?
40 A. So, 100 per cent of children, so every child,
41 regardless of who their out-of-home care provider is --
42
43 Q. So each child has a Child Safety Officer?
44 A. They ought to.
45
46 Q. They ought to. Do they?
47 A. No, because there's vacancies in the Child Safety

1 Service.
2
3 Q. So, what percentage do you know don't have a Child
4 Safety Officer?
5 A. I don't know the figure for that as of today, and it
6 fluctuates from day-to-day. What I can say is if they
7 don't have a Child Safety Officer, they're still allocated
8 within a team. So, there is an officer responsible for
9 them, but it won't be to the same level of support and
10 supervision as a child who has an allocated worker who is
11 present at work.
12
13 Q. But that's to be taken - there's two different teams
14 you're talking about: there's the aspirational Care Teams
15 which you've been talking about?
16 A. Yes.
17
18 Q. Then there's the teams in the north, the north-west
19 and the south. Is that the case?
20 A. Maybe I'm confusing things because I'm --
21
22 Q. That's why I just want it clear in my mind.
23 A. Yeah, yeah. I am talking about two different types of
24 teams. So, putting Care Teams aside and talking about
25 Child Safety teams, they're part of the structure within
26 the Child Safety Service. So, each region has, for
27 example, case management teams. The south is a big region,
28 it has quite a number. There may only be - I think there
29 may be two or three in each of the north and north-west.
30 They each have around six, five or six, Child Safety
31 Officers reporting to one Practice Leader. You'll have two
32 teams who each report to one Practice Manager above that.
33 So, those teams are responsible. They are really the
34 guardian's delegate. They're responsible for the child's
35 case management.
36
37 Q. From a child's point of view, the child will know
38 that - should know that somebody cares for them, and that
39 would normally be the Child Safety Officer?
40 A. Yes.
41
42 Q. Now, that safety officer will be away on leave from
43 time to time, be away sick and perhaps need to change from
44 time to time.
45 A. Yes.
46
47 Q. But you would know, would you not, roughly how many

1 Child Safety Officers you have?
2 A. (Witness nods.)
3
4 Q. And you'd also know roughly how many vacancies you
5 have?
6 A. Yes.
7
8 Q. Are you able to give me those figures?
9 A. Yes. So, the establishment for the Child Safety
10 Service - I actually can't give you the figures because the
11 establishment includes the Advice & Referral Line and that
12 sort of thing, so it really is quite confusing. But the
13 average caseload for the Child Safety Officers should be
14 around 15 children each. But what we find is that the more
15 vacancies we have, and I think at the moment we're sitting
16 somewhere between 26 and 30 vacancies, obviously that
17 number then increases because we have vacancies.
18
19 Q. I'm just thinking from the perspective of the child
20 who's gone through the trauma of the events leading up to a
21 removal, the removal itself and settling into a new family
22 of some description: the person who would provide the
23 most - the best level of safety and protection for that
24 child at the present time is the Child Safety Officer?
25 A. Absolutely.
26
27 Q. But that seems to be fairly under-resourced at the
28 moment; would that be a fair comment?
29 A. Yes. I don't know that it's a matter of resourcing,
30 but we're experiencing a challenge in being able to appoint
31 people to Child Safety Officer roles. We are unable to
32 fill all of our vacancies through our recruitment
33 strategies, so we really are having a workforce planning
34 problem that's persisted for some time now. Despite
35 different strategies being used to try and fill that
36 workforce, it's not successful. This is the challenge that
37 we are faced with, that we don't have enough applicants who
38 we are able to appoint to these positions. It may be in
39 part because there's a limited market in Tasmania, we're
40 competing with other agencies, government agencies who are
41 also recruiting people with the same or similar
42 qualifications, but also in the non-government sector.
43
44 There's been a lot of investment in recent years in
45 Children and Family Services sector as a whole and I think
46 we're competing for a very limited pool of people, so
47 that's a challenge, but also within our own workforce,

1 inadequate workforce planning perhaps has led to a
2 structure which means that we have quite a high number of
3 more senior positions. So, when we hear statements about
4 high staff turnover, retention issues, burnout, in many
5 cases what's happening is that the frontline is
6 continuously being promoted up and the next level is
7 continuously being promoted up. So what that does is a
8 draw straight up off our frontline, leaving vacancies in
9 Child Safety Officer positions.
10
11 Q. And I guess a lot of those are filled by fairly
12 inexperienced officers?
13 A. Yes.
14
15 Q. Which then adds to the issues that you have to
16 address?
17 A. It does add to the issues. We also provide as much
18 flexibility as we can. We obviously support promotional
19 opportunities, we support people to have flexible work
20 arrangements for family and other reasons, we support
21 people in their career progression to take leave without
22 pay and take up secondment opportunities, we support people
23 to purchase leave for their wellbeing: all of these things
24 we support but all of these things, the flow-on effect is
25 vacancy on the frontline.
26
27 Q. You're extraordinarily experienced in this, because
28 you started off in 2004, I think you told us, as a case
29 support officer. So you've got 18 years of experience.
30 How do you think it can be solved, if it can, because you
31 said it was a longish-term problem. What do you see? If
32 you had your druthers and it was said, "All right, how do
33 we fix it?", how do you fix it?
34 A. The frontline staffing issue to make sure that every
35 child has a Child Safety Officer who is present and
36 available for them. That issue. Yes. I think that we
37 need to be strategic in our workforce planning. I think
38 that resourcing does come into it; I don't think that we do
39 have enough staff to meet our obligations, but I also think
40 that of the staff and the resource that we do have, it
41 hasn't been effectively managed.
42
43 So we have undertaken a review to inform workforce
44 planning strategy. We have very recently appointed a
45 workforce planner. There's some immediate issues that we
46 can deal with, but we need to have long-term strategy in
47 place also. So, some of those things include developing a

1 relief, a proper relief pool. We've tried relief pools
2 before; they don't work unless the relief people are
3 permanent people and that's actually the job that they
4 want. It can't be an entry pathway for fixed-termers,
5 because as soon as a permanent position becomes available,
6 we lose our relief worker and we're back to square one. So
7 we need proper relief arrangements.
8
9 We also need to be doing long-term planning with the
10 University of Tasmania and other learning institutions so
11 that we have a supply of qualified workers, but I also
12 think that we do need to diversify our workforce. We place
13 a lot of responsibility on the Child Safety Officers to be
14 everything to everyone, and I don't believe that's
15 necessary. There's been some progress there; some of the
16 positions that have been created over the years are to
17 tackle that very issue.
18
19 So, we've had coordinators appointed. We've had unit
20 coordinators to support the teams with administrative
21 functions. We've had support workers who are, effectively,
22 case aids who can support the Child Safety teams. I think
23 there's more that can be done there. I think the greater
24 diversity we have in the workforce, the less pressure that
25 there is on the Child Safety Officer to be doing things
26 other than their core duties. And part of their core
27 duties really should be that direct relationship with that
28 child, knowing them, being their go-to person, being
29 available.
30
31 Q. That would be one of the really major factors to
32 provide the Child Safety if the child was at risk or felt
33 they were at risk or something had happened, they knew that
34 they could contact a person?
35 A. Yes.
36
37 PRESIDENT NEAVE: Q. So we know that there is a dearth
38 of Child Safety Officers and you've talked very eloquently
39 about that. You also said, I think, that not all children
40 have a Care Team and that some Care Teams are pretty
41 limited. They are basically maybe a Child Safety Officer
42 and one other person. So, what's the gap there? Can you
43 talk about that a little bit?
44 A. Yes. So, there has been really positive progress with
45 Care Teams, and some where I - I often have cause to look
46 in the information system and look at what sort of Care
47 Team arrangements there are for children, and they range

1 from being really impressive, really good, a good group of
2 people who are having really robust child-focused
3 conversations and developing really good plans.
4
5 But then we also have at the other end of the spectrum
6 children who don't have a Care Team at all. Their Child
7 Safety Officer, perhaps their case is allocated to the
8 Practice Leader because there is no Child Safety Officer,
9 or the Child Safety Officer's only just picked up the case
10 and hasn't formed that Care Team yet.
11
12 And then we have everything in between. So, what we
13 need to do is keep taking these incremental steps until
14 every child has a good Care Team, because that's the way
15 that we want to - I don't really like the term "case
16 management", but really that's what every child deserves,
17 to have the right group of committed people.
18
19 Q. Would you have a figure for the proportion of children
20 who don't have a Care Team?
21 A. No.
22
23 Q. A rough estimate?
24 A. That's something that I'd have to take on notice. As
25 I mentioned before, I could give a figure, but it would be
26 a tick-box figure, because we can tick the box for a child
27 having a Care Team, but if that's only two people and
28 they're only needing to talk about the issues that happened
29 last week in their residential care placement, that's not
30 really a Care Team, that's a couple of professionals coming
31 together and being almost reactive or supporting each other
32 in the day-to-day. I'd need to see that there's actually
33 goals that the child has been involved in developing and
34 other people, and that the group are working toward
35 achieving those goals for me to be satisfied that that's an
36 effective Care Team.
37
38 I also think that for a Care Team to be considered
39 effective for an Aboriginal child, it must have
40 representatives from the Aboriginal community on it. So,
41 I'm quite loath to give a figure that misrepresents our
42 progress, but what I can say is that I - myself and the
43 principal practice managers within our service are
44 completely committed to making sure that we get there.
45
46 There's certainly challenges in establishing Care
47 Teams beyond the practical challenges though. Some of

1 those in your introductory statement about the culture
2 within the Child Safety Service, that certainly rings true.
3 It's very difficult for Child Safety Officers to get Care
4 Teams off the ground when there is a history of conflict,
5 not just between the various parties, but between the
6 various parties and the hostility, almost - well, indeed,
7 hostility toward the Child Safety Service itself. It takes
8 a lot of preparation to get that off the ground and it
9 takes a lot of stamina to run it. If anyone's ever run or
10 facilitated an extremely difficult conference, it's like
11 the Child Safety Officer being asked to do that for at
12 least 15 children and then do it multiple times. I believe
13 that once we can overcome that first stage of extreme
14 tension, hostility, past grief, everything that comes to
15 the fore in the Care Team, once we get past that first
16 hurdle, every time it gets easier.
17
18 But I can see why there is some - I don't know whether
19 it's a reluctance, whether it's an avoidance, whether it
20 purely is just the challenge of dealing with all of that
21 complexity that can take quite a long time for the Care
22 Team to get off the ground and running.
23
24 PRESIDENT NEAVE: Thank you for that.
25
26 COMMISSIONER BENJAMIN: Q. When you look at the numbers
27 you gave me, and I've always got check my arithmetic - it's
28 not my strong suit - but if I multiply 26, you said you run
29 between 26 and 30 Child Safety Officers vacancies at any
30 time?
31 A. Yes.
32
33 Q. I multiply that by 15, that's about just under 400?
34 A. Some of those vacancies include other parts of the
35 service.
36
37 Q. Oh, right.
38 A. Yes, so other parts of the portfolio, like Advice
39 & Referral Line. And yes, I believe that some of them are
40 actually support workers and the like. They're not all
41 Child Safety positions.
42
43 Q. Right, because I'm going from there to there, not
44 going above it, looking at the problem, going across.
45 Thank you.
46 A. However, there are significant vacancies across the
47 Child Safety Service, in some regions more than others, and

1 those vacancies are also exacerbated by leave, and
2 particularly COVID-related leave. At the moment, those
3 services are, and one in the north in particular, is under
4 enormous strain and has been for some time, which means
5 that there are children who don't have a Child Safety
6 Officer and haven't had for some time. So it's a very
7 serious issue for our service and not one with a quick fix,
8 unfortunately.
9
10 COMMISSIONER BROMFIELD: Q. Ms Lovell, while we're on
11 the issue of the vexed issues for Child Protection, and I
12 think it's important that we understand this so that we
13 don't, as an inquiry, unduly criticise the frontline when
14 they're doing everything that they can in a tough working
15 environment.
16
17 Thinking back on your two decades of involvement
18 within Child Protection, would you care to make any
19 observation around whether the complexity of families has
20 changed or whether the demands, the volume of demand on the
21 Child Protection Service has changed in those two decades?
22 A. I don't know that the complexity of families changed.
23 I think our understanding around the issues and the ways
24 that we need to respond has changed. I think the demands
25 on the child safety service increased. I think - I know
26 that we struggle to keep up with reasonable community
27 expectation around the services that we deliver and the
28 safety and quality of those services.
29
30 We know that we can't keep up with that demand, and I
31 guess that's part of our reform difficulty; that we
32 acknowledge that we're not doing well in relation to one
33 aspect; we commit to doing better, we have a strategy
34 around how to do that, but it's immediately superseded by
35 the next area where it's determined that we're failing, and
36 so on and so on.
37
38 So I guess it's not that we're not progressing and
39 improving, but that is - I ask myself, "Why are we only
40 just now developing a learning pathway around sexual abuse,
41 around preventing and responding to sexual abuse?" But
42 then I think back over the last decade of the different
43 waves of focus that we've had, and it's because we've also
44 been responding to the findings of child death inquests, so
45 we're focused on infants. You know, our understanding of
46 cumulative harm has emerged - thank you - so we have a
47 focus on that. We're adopting a new practice framework,

1 Signs of Safety, a new way of engaging and working with
2 families more effectively, so we focus on that. Family
3 violence, that's been a recent focus as well.
4
5 We can't do everything at once, so the expectation on
6 us - we certainly agree that we need to improve in all of
7 those areas. That's what continuous improvement is about.
8 But we can only do so much at once, and the more things we
9 try and do simultaneously, it seems, the more that our
10 efforts are diluted and we don't do anything as perfectly
11 as we would aspire to. That's been my experience.
12
13 COMMISSIONER BROMFIELD: Thank you.
14
15 MS ELLYARD: Q. Commissioners, can I move to ask
16 Ms Lovell some questions about the care concern processes?
17 So bringing the focus, Ms Lovell, to circumstances where
18 allegations of child abuse of one kind or another might be
19 made. And I recognise that Mr Pervan's statement indicates
20 that there are new processes in train, perhaps picking up
21 your point, everything's changing. But right now as I
22 understand it there are two potential pathways for the
23 investigation of concerns about the wellbeing of a child in
24 out-of-home care: one's a quality of care review and one's
25 a serious abuse and neglect investigation. Is that right?
26 A. Yes.
27
28 Q. And thinking about - and the policies that are
29 attached to Mr Pervan's statement, and allegations of
30 sexual abuse are allegations that would ordinarily fall
31 into the category of the severe abuse and neglect
32 investigations?
33 A. Yes.
34
35 Q. Although it does appear from the materials about
36 quality of care reviews that whether or not there are
37 proper responses to harmful sexual behaviours in the home
38 might be one of those borderline issues that can sit in
39 either category?
40 A. Yes. At the moment, because we deal with such small
41 numbers of either form of concern, there is scope for
42 myself and the Director to assist with making that call.
43 And while that's happening, I would make the call that
44 anything relating to sexual abuse of children be dealt with
45 using the investigation approach and a degree of
46 independence, not as a quality of care concern issue.
47

1 Q. Thank you. I wanted to ask you now some hypothetical
2 questions - and these are pure hypotheticals, they are not
3 linked to any particular case - just to help understand how
4 those processes might work and the way in which, right now,
5 a child who's alleged to have experienced one or other form
6 of sexual harm in out-of-home care might be dealt with.
7
8 Can I take as a hypothetical example a child who's
9 living in an out-of-home care placement that's directly
10 arranged by the department who is observed at their primary
11 school to be displaying problematic or harmful sexual
12 behaviours, and of course it's unknown what the origin of
13 those behaviours are.
14
15 Assuming this is a child who does have a Child Safety
16 Officer, how would you expect that the Child Safety Officer
17 will find out about those behaviours, as the starting
18 point?
19 A. The Child Safety Officer's highly likely to hear about
20 those through the school, so someone from the school will
21 report it. They may report it to the Advice & Referral
22 Line, but they're more likely to know that the child's
23 allocated in the Child Safety Service and make contact with
24 that Child Safety Officer directly.
25
26 Q. So, the school wouldn't, for example, contact the
27 out-of-home carer, they would contact the department?
28 A. No, the school will contact the Child Safety Service.
29 Yes, they're mandatory reporters and - yep.
30
31 Q. But again, thinking about them, they're mandatory
32 reporters but at the same time the Secretary is this
33 child's parent. So as I understand it, though, the
34 notification will come to the Child Safety Officer in their
35 capacity as the receipt of a mandatory notification, not
36 because they're the delegate of the child's parent?
37 A. Both.
38
39 Q. Both?
40 A. Both, I believe. I think it would be really unlikely
41 that a professional from a school would make contact with
42 the out-of-home carer or the care provider; they're far
43 more likely to contact the Child Safety Officer. They do
44 contact the Child Safety Officers when they have concerns
45 for children in a school context.
46
47 Q. And once the Child Safety Officer receives that report

1 from the school, that child X has been observed to be
2 displaying harmful sexual behaviours in school, what would
3 be the expectation of what the Child Safety Officer did?
4 A. So this actually isn't necessarily a care concern
5 scenario. So, our care concern procedures cover more when
6 the allegation is related to the carer, so something that
7 the carer has either done or omitted to do. But when we
8 receive concerns about children who are in out-of-home care
9 generally, so observations like that where there's no
10 alleged person believed responsible, that would still be a
11 Child Safety assessment, which is very, very similar, it
12 goes into the same system, into the Child Protection
13 information system and it still requires assessment. It
14 just means that we're not necessarily focusing straight
15 onto the carers and either the quality of care that they're
16 providing or an allegation that the child's been abused or
17 neglected by them.
18
19 Q. So in that respect the response would be the same for
20 a child who wasn't in out-of-home care; they're displaying
21 harmful behaviours at school, there's a mandatory
22 notification to the department, but there's a completely
23 open mind about the source of those behaviours and whether
24 or not the child is a victim of anybody?
25 A. Yes, so we need to gather information to establish
26 that, so that goes into the system as a notification, a
27 self-generated notification by the Child Safety Service
28 which triggers an initial assessment; it certainly triggers
29 consultation with more senior staff from that team or more
30 broadly in the service and then the assessment follows.
31 So, depending on the circumstances, it might be different
32 who we consult with and whether there's a report made to
33 police if we believe that there's abuse that's occurred.
34 It might be that we have a secondary consult with a
35 specialist service like Laurel House or the Sexual Assault
36 Support Service to understand more about the behaviour
37 that's been observed. It may be that there's a
38 conversation - it's likely that a conversation needs to be
39 had with the child to understand more of what's going on
40 for them.
41
42 Q. Do you mean this is a child who has a Care Team?
43 Would there be a role for a Care Team in responding in this
44 circumstance?
45 A. Yes.
46
47 Q. You indicated that perhaps because of the small

1 numbers you and the Director who works underneath you have
2 the capacity to have some direct involvement in this, but
3 what's the level of supervision or oversight of that
4 process to make sure that it's being done appropriately and
5 that the child's interests are being appropriately
6 understood and responded to?
7 A. So, assessments within the Child Safety Service are
8 managed by the managers of those regional services, so
9 there is consultation that occurs within that service, but
10 I'm certainly not the delegate, that doesn't come to a
11 statewide level.
12
13 Q. So, sitting as the Executive Director, what's the
14 process by which you feel comfortable, if you do feel
15 comfortable, that a child who displays behaviours in that
16 way would end up getting a response that was appropriate?
17 A. At the moment I have to trust the Child Safety Service
18 and the professionals who work in that service to do their
19 job, and their job is to assess and respond to allegations
20 of abuse and neglect for children. So, the sorts of
21 matters having - the sorts of matters that I would become
22 involved in and be notified of are the ones where there's
23 been an allegation that the carer has caused harm to the
24 child or may cause harm to the child; they're the ones that
25 are escalated to me via the management reporting line.
26
27 Q. Perhaps if we take then a second hypothetical example.
28 Let's say that a child makes a disclosure that a child
29 living in out-of-home care, let's say a placement where the
30 carers are supported by a non-governmental organisation
31 rather than directly by Child Safety Services. The child
32 makes a disclosure that they've been sexually touched by a
33 carer's friend, someone associated with the carer, perhaps
34 not necessarily the carer itself, and that's a disclosure
35 that's made to a therapeutic person working with the child.
36 Again, what's the process by which the department - you
37 would hope the department would find out about that and
38 what's the process of investigation that would follow?
39 A. Yes, it's a similar process, only I think that
40 scenario that you've described would constitute a care
41 concern. So, when we know - when it's alleged that it
42 relates to the out-of-home care context, then that's when
43 it goes in as a care concern and that's where there's a
44 care co-ordination meeting held almost straight away with a
45 group of practitioners from that service who make a
46 determination, firstly as to whether or not it's a quality
47 of care issue or an investigation of abuse issue. There's

1 referral to the police immediately when we receive that
2 information, so then the protocol between the Child Safety
3 Service and Tasmania Police also kicks in where we use a
4 joint approach to responding to these matters; the police
5 taking the lead in the criminal investigation and the Child
6 Safety Service taking the lead around the safety of the
7 child during the period of that investigation.
8
9 The Care Coordination Group will also consider the
10 best way to approach it even within those two streams,
11 including what support the child might need, who's going to
12 be the person that meets with them and has the conversation
13 with them, what support do the carers need in working
14 through this process, the sequencing of events, those types
15 of things, so that's dealt with through a sequence of care
16 coordination meetings within the service.
17
18 Q. Ultimately, leaving aside the question of processes
19 that might be followed in the police and so forth, there's
20 got to be an assessment of whether the child's at risk in
21 that placement?
22 A. Yep.
23
24 Q. And whether the child should be removed from the
25 placement?
26 A. Yes.
27
28 Q. And who makes those calls? You've talked about the
29 sharing of power but there's still got to be a
30 responsibility, I take it?
31 A. Yes, that's our responsibility to determine whether or
32 not the child's safe where they're living or whether
33 they're going to need to move to an alternative placement
34 and that delegation currently sits with the Director.
35
36 Q. Is there a risk framework or tool that assists the
37 Director in making that decision about whether or not a
38 child in a particular circumstance is at risk and should be
39 removed even though the removal itself might cause harm?
40 A. So at the moment the Director receives a briefing,
41 it's normally a written - well, there is always a written
42 briefing because that's what goes into the information
43 system as the record but there's also a conversation - at
44 least one conversation around that, that's a really
45 significant decision to make for a child.
46
47 Q. It's what might be called a kind of an exercise of

1 structured professional judgment, and I'm keen to know what
2 the structure is against which those decisions might be
3 being made. Is it the risk framework, is it some other
4 policy document?
5 A. Yes, at the moment there's the Tasmanian Risk
6 Framework but there's also the Signs of Safety Approach.
7 With these matters I - the briefing includes the
8 perspectives of everybody involved and a description of the
9 risk in accordance with the Tasmanian Risk Framework
10 generally. So, it will speak to the immediacy, the
11 severity, the pros and cons to either scenario, the
12 attempts that have been made to - well, to either resolve
13 the issues so that the child can remain where they are, or
14 the fact that that's just not feasible, the level of risk's
15 too high and it's completely unacceptable and the
16 recommendation will be that there is no other option to
17 secure safety for the child other than to have them move
18 placement.
19
20 Q. Can I ask a hypothetical of a very different kind.
21 This is a hypothetical, assume that the child is living in
22 an out-of-home care placement where the carers are directly
23 supported by the department and a Child Safety Officer
24 becomes concerned about whether or not their colleague, the
25 colleague working directly with that family, is becoming
26 too close or perhaps forming a personal or inappropriate
27 attachment with the child, perhaps taking the child out on
28 their own, something of that kind, and has a concern that
29 proper boundaries are not being maintained between the
30 worker and the child.
31
32 What is your expectation of what that person with the
33 concern will do about the concern and how the concern would
34 be investigated?
35 A. Sorry, it's a staff member?
36
37 Q. Concerned about a colleague?
38 A. Concerned about a colleague, yeah, they report that to
39 their supervisor and the very first thing that any
40 supervisor within the Child Safety Service or Children and
41 Family Services more broadly do is contact People
42 & Culture.
43
44 Q. What does People & Culture then do?
45 A. People & Culture step in straight away and provide
46 guidance around the steps to take in raising that concern
47 with the person involved. I receive a briefing very

1 quickly in relation to those matters. We look for any
2 other relevant information, because often there is other
3 relevant information that's not - you know, it might not be
4 the first observation or complaint that speaks to this
5 concern. People & Culture will, if need be, they'll
6 prepare the minute for the Secretary to make a decision
7 about employment direction and potentially having a staff
8 member stood down.
9
10 Q. And what's happening for that child while that process
11 is going on, focused on the --
12 A. The first thing we would do is interrupt so that that
13 staff member doesn't have any contact with that child.
14 We're fortunate that we haven't actually been faced with
15 this scenario on very many occasions at all, so we don't
16 have any current reports that we have people in our
17 workforce who have or may sexually abuse children, I'm
18 satisfied of that at the moment, but that doesn't mean that
19 we shouldn't be responding to other observations around
20 conduct that may lead to the abuse of a child or even lead
21 to a culture, the sorts of cultures where abuse can occur.
22
23 Q. Thank you. I note the time, Commissioners, but with
24 the Commissioners and the stenographer's leave I'll just
25 raise the last brief hypothetical and this is perhaps a
26 hypothetical with two parts, Ms Lovell.
27
28 One of the themes that's going to emerge in some of
29 the evidence this week is a theme of older children, and
30 when I say "older children" I'm talking about children
31 perhaps 15 and above who are not in placements, who may not
32 be subject to orders at all but who are homeless or at risk
33 of homelessness and perhaps exposed to the potential of
34 harm including the risk of sexual exploitation. We're also
35 aware of cases of children who are on orders who absent
36 themselves from placement, run away and are hard to protect
37 in that way.
38
39 Can I ask you this question and perhaps you can answer
40 it either way, either a child who's in the system but not
41 in their placement or a child who hasn't been brought into
42 the system.
43
44 Say a child is engaging in risk taking behaviours,
45 they're running away from their placement, they're
46 associating with older males, they're displaying
47 behaviours, having new clothes and gadgets that strongly

1 suggest that they're at risk of or are being exploited.
2 Thinking firstly about a child who is in an out-of-care
3 placement, what are the responses that are available if and
4 when the department becomes aware of that behaviour?
5 A. In the opening statement that you made today, all of
6 the observations within that rung true to me about the risk
7 of exploitation for these children and why that happens.
8 So I think that preventative measures around making sure
9 that that child does have secure networks. If we make
10 those observations and that prevention hasn't been taken
11 our first response needs to be making sure that they can
12 access safe people: safe people so that they can disclose,
13 safe people who can help them to get to Tasmania Police,
14 safe people who can provide them with a safe place to stay
15 and interrupt that exploitative or abusive behaviour; that
16 has to be our first step to try to build as much safety as
17 we possibly can for children and young people; to make sure
18 that they have a placement where they can come to at any
19 time of day; to make sure that they know, wherever they
20 are, that they can call someone who will come and bring
21 them to safety and find them safety: that needs to be our
22 response.
23
24 Q. What about if this is a child who isn't currently
25 known to Child Safety Services who isn't on an order but
26 who is running away from home and engaging in all those
27 behaviours of concern, do you accept that they would be
28 capable of meeting the definition of a child at risk?
29 A. I believe that they are children at risk, yeah.
30
31 Q. And that they could well be children who might be
32 appropriately assessed to enter the statutory system,
33 including potentially an out-of-home care placement?
34 A. The difference is that children who enter the
35 statutory system do so because they don't have a parent who
36 is willing or able, so for some of those other children who
37 aren't in the statutory system, yes, they're at risk but
38 the willingness and ability of their parent, either at that
39 present time or in the future, is untested, so I think for
40 a lot of those children the efforts are around identifying
41 whether or not there's a way that their family or someone
42 or some people within their network can be supported enough
43 to achieve enough safety for them. I don't think that it's
44 an automatic, every child who's at risk needs to enter the
45 statutory system because in fact they'll be at just as much
46 risk potentially if that's where they're at, those problems
47 will still be present for them whether there's a Care and

1 Protection Order or not.
2
3 Q. Some of the evidence that the Commission has received
4 suggests that the experience of non-governmental
5 organisations is that for a child at the age of 15
6 displaying those behaviours and not on an order, they're
7 highly unlikely to be taken into the system and placed on
8 an order because of a perception that they're reaching an
9 age where they can self-protect or self-select. I wanted
10 to ask you, firstly, are you familiar with that perception
11 that we've heard about and do you think there's any
12 accuracy in it?
13 A. I am familiar with that perception, yes. I think
14 we're talking about a wicked problem, a problem that's been
15 around for a long time, I don't think that there are any
16 easy answers. So, I think in the services who are involved
17 with children who are in that situation that you described,
18 who are not living with their parents, they're still young,
19 they're in their early-to-mid-teens, they're drifting
20 between people's couches and shelters and sometimes going
21 home, I think that they're highly vulnerable.
22
23 But I think as a community our efforts need to be
24 geared toward achieving stability, responding to their
25 wellbeing needs, getting them to a point where they are
26 safe, identifying safe people, building their capacity to
27 protect and care for that child.
28
29 I don't think - I see that it's tempting for people
30 who sit with that sense of risk and responsibility when
31 they're faced with these children, I can see that it's
32 tempting for them to say, if only, if only Child Safety
33 would open its doors these children would be safe. But
34 that's not the fact, we'd still be relying on those
35 services to do exactly the same thing. There's not a lot
36 that Child Safety having orders - the order itself can't
37 bring safety to these children who are at risk of
38 exploitation.
39
40 One of the things that we need to be doing is
41 interrupting and tackling the issue of the exploitation
42 itself and that largely sits with Tasmania Police to do so,
43 and I know that they have a commitment to that. I guess we
44 need to find ways to be supporting children to engage with
45 young people to engage with those processes so that we can
46 disrupt that. We need to be finding ways, preventative
47 measures to support children to avoid - to at least be able

to understand and ideally to avoid those scenarios.

I don't think getting a Care and Protection Order fixes the problem. I think the Child Safety Service has a role to play but, as I said much earlier, it can't be the only service that protects children, it can't be; it can't do it alone.

MS ELLYARD: Thank you, Ms Lovell. Thank you, Commissioners. That's the evidence, with my gratitude to the stenographer who's carried on beyond the designated time.

PRESIDENT NEAVE: Thank you very much for your evidence. Thank you, we'll now have a break for lunch, thank you.

LUNCHEON ADJOURNMENT

PRESIDENT NEAVE: Ms Ellyard.

MS ELLYARD: Thank you, Commissioners, the next witness is Robyn Miller and I'll ask her to come into the witness box and take the oath or affirmation.

<ROBYN MAREE MILLER, sworn: **[3.06pm]**

<EXAMINATION-IN-CHIEF BY MS ELLYARD:

MS ELLYARD: Q. Thank you, Dr Miller, please feel free to take a seat and put the Bible down. Can I ask you to tell the Commission please your full name?
A. My name is Robyn Maree Miller.

Q. And your present professional address?
A. Is in South Melbourne, in Cecil Street, South Melbourne.

Q. And your present professional occupation?
A. I'm the CEO of MacKillop Family Services.

Q. Dr Miller, you've made a statement to assist the work of the Commission which was signed by you on 9 June 2022. Do you have a copy of that statement with you?
A. I do.

Q. I understand that there's a matter of clarification that you'd like to raise in relation to paragraph 33?

1 A. Yes.
2
3 Q. So I'll just draw your attention to paragraph 33. You
4 refer there to the introduction of what's called the Safer
5 Children's Framework and its implications for the Best
6 Practice Case Practice Model. What's the clarification
7 that you'd like to make?
8 A. I'd like to clarify that the Safer Model is actually a
9 particular framework for Child Protection only around risk
10 assessment, it hasn't superseded the Best Interest Case
11 Practice Model and the resources are still relevant. It's
12 a very new development and there's not a lot of information
13 available, so I have clarified it with very senior people
14 today, and the Best Interest Case Practice Model is across
15 Child Protection, the non-government services and
16 out-of-home care and remains the overarching practice
17 approach or practice model within Victoria. Safer is a
18 component of it just for Child Protection and that's around
19 risk assessment, but the principles that are in the Best
20 Interest Case Practice Model remain the same for the risk
21 assessment component as well; it's just a more granulated
22 guide for Child Protection.
23
24 Q. Thank you, Dr Miller, so with that clarification made
25 are the contents of your statement otherwise true and
26 correct?
27 A. Yes.
28
29 Q. I take it from what you've said, is that there is
30 still benefit from the Commission in hearing from you in
31 considering the best practice case model because it
32 continues to be used in Victoria and continues to be a
33 useful reference point?
34 A. Absolutely.
35
36 Q. Thank you very much.
37
38 COMMISSIONER BROMFIELD: Ms Ellyard, just to avoid any
39 potential perception of conflict, I just wanted to
40 acknowledge that I was involved with Dr Miller in
41 developing the Specialist Practice Resources that sat under
42 the Best Interest Case Practice Model.
43
44 MS ELLYARD: Yes, thank you, Commissioner Bromfield.
45
46 Q. Dr Miller, you've indicated that the role you
47 currently hold is the Chief Executive Officer of MacKillop

1 and I do want to come to that, but first perhaps by way of
2 exploring the breadth of your practical experience, you
3 indicate in your statement that you started your
4 professional career as an individual, couple and family
5 therapist, and part of your professional background is that
6 you started as a social worker and as a family therapist.
7 You then moved from there, as I understand it, to work
8 firstly in the Child Protection system in Victoria; is that
9 right?
10 A. Yes. Yes, I had 10 years from 1980 in the field as a
11 family counsellor working in family support, and then
12 worked in Child Protection in after-hours, and then went to
13 family therapy studies and then worked as an individual and
14 family therapist after that clinical training, and then
15 went into the department in 2006 as principal practitioner,
16 becoming chief practitioner, that was a new position
17 created to lead practice at a senior level, and then to the
18 Royal Commission as a consultant and then to MacKillop in
19 2016.
20
21 Q. Thank you. In the course of your 30 years of
22 professional life you've worked directly with families,
23 including families perhaps facing some of the challenges
24 that the Commission has heard arise for the families of
25 children in out-of-home care?
26 A. Absolutely. So, I have specialised working with the
27 most marginalised populations and particularly with areas
28 of child abuse, sexual abuse and family violence. So, the
29 whole trauma field was something that was very important to
30 be aware of.
31
32 Q. And similarly, the work that you've done directly with
33 families included families where there were allegations or
34 experiences of child sexual abuse?
35 A. Yes, right throughout my career.
36
37 Q. And then your role as the principal practitioner or
38 the chief practitioner at the department in Child
39 Protection at the Department of Health and Human Services
40 in Victoria, can you summarise briefly please what your
41 role was there, perhaps with particular reference to issues
42 of child sexual abuse?
43 A. Yes. Well, prior to going into the department I was
44 part of a specialist team at the Bouverie Family Therapy
45 Centre which was part of La Trobe University, and we were
46 charged with working with families where there had been
47 intrafamilial abuse or the sexual abuse of children by a

1 trusted adult. That included sibling abuse and
2 intrafamilial abuse is the most frequently occurring form
3 of sexual abuse. Based on that work I did a lot of
4 training for the department and a lot of supervision and
5 consultation and I was also in private practice, I was half
6 time at Bouverie, so my experience had grown.
7
8 As I said, I was at Bouverie for 14 years. For ten
9 years - before I went to Bouverie and during my family
10 therapy training I was doing after-hours Child Protection
11 work which meant that I had a knowledge of the statutory
12 system. I had also worked with sex offenders, so the
13 offending. We were one of the only teams that worked with
14 victim-survivors, the non-offending parents and the
15 offender where appropriate. So, we'd worked with a very
16 specialised team doing that work and therefore we were
17 asked to train many others.
18
19 In that context then they developed - in 2005 there
20 was a big reform in Victoria, the Every Child, Every
21 Chance. The Executive Director at the time approached me
22 to - because of the broad experience I had saying they
23 wanted somebody who would be a practice leader rather than
24 a manager or a director, but to work very closely with the
25 operational directors to raise the quality of practice. So
26 in that role it became clear that there was a very great
27 awareness of the lack of knowledge around children with
28 problem sexual behaviours, particularly in out-of-home
29 care, and that was one of first requests that I had
30 actually.
31
32 So it was a broad role where it was envisaged that I
33 would work with the most high risk cases in the state,
34 report to the Minister on enquiries and particular reviews
35 of complex cases. So, I would also be asked then to train,
36 and I initiated that development of the Best Interest Case
37 Practice Model because there was new legislation and there
38 was policy, but there weren't the practice documents that
39 were enough to bridge the gap.
40
41 So, the Best Interest Case Practice Model was written
42 from about late 2006, 2007, 2008. It was first published
43 in 2008; it became clear then that we needed more detailed
44 practice resources for frontline people, so I approached
45 the Australian Institute of Family Studies and some
46 specialised consultants to co-author with me some of these
47 practice guides, and as Commissioner Bromfield has said,

1 that was a unique partnership because what we were able to
2 do was develop cutting-edge research and put it into
3 practice terms that were relevant in the here and now, if
4 somebody was doing a home visit today. So, it was
5 translating the knowledge from research into practice and
6 useful resources.
7
8 Q. Perhaps it's a very obvious question, but assuming
9 that Child Protection practitioners have all been to
10 university, they're all trained as social workers, they
11 bring in existing knowledge to their work, what's the
12 importance of a practice guide of the kind that you
13 developed?
14 A. The work is so complex that no two-year or four-year
15 social work degree or psychology degree could possibly
16 equip you to understand the knowledge that you need to have
17 around sex offenders, around child development, around the
18 impact of trauma at different ages and stages, and in fact
19 that was one of the first guides that we wrote, the Child
20 Development and Trauma Guide.
21
22 It was really important that, particularly Child
23 Protection, but also Family Services and out-of-home care
24 understood the brain science that was emerging, and there'd
25 been a great increase in knowledge in the field from
26 neuroscience and the impact of violence, the impact of
27 sexual abuse particularly, which had been known for
28 decades, but what the brain science actually documented was
29 the impact of abuse and neglect on the developing brain and
30 how that cascaded into every other part of the child's
31 development, including how they learned to read and write.
32
33 So, what we had to do was really try to help build the
34 confidence, and this notion of the impact of neglect had
35 also been "neglected", excuse the pun, but in Child
36 Protection and particularly in the Children's Court there'd
37 been a focus on, you know, injury to the child that you
38 could see. Whereas the impact of chronic neglect and the
39 impact of witnessing, experiencing - because children don't
40 just witness, they literally feel it, the impact of
41 violence, and family violence is ubiquitous, we know that
42 that impact of the adrenaline or adrenaline cortisol that
43 floods the child's body when they're in a state of terror
44 or fear and that they sense that from their parent. And
45 when sexual abuse is happening, and there is a correlation
46 between offenders - the only thing that correlates with sex
47 offending is that the offender is more likely to be violent

1 in the home, but not always. So, what's not well
2 understood and why Child Protection work is needed, more
3 practice resources, was to actually develop the very
4 specialised forensic sort of work that you need to know
5 about how do offenders groom, for example, and what can be
6 quite counter-intuitive. You know, "Oh, but the child went
7 to him. The child sat on his knee". Well, yes, that's
8 because the child's brainwashed to do that in front of
9 professionals because the offender is so skilled at
10 silencing the child.
11
12 So what we had to train people in was the whole
13 dynamics, what we call the dynamics of sexual abuse, and
14 it's not common sense, you know, it actually requires
15 training. And then, how do you apply that to a home visit?
16 And when you're a new graduate or even someone who hasn't
17 had recent experience it's asking - it can be dangerous not
18 to have well-trained and well-supervised frontline
19 practitioners because you can miss things, and even the
20 best of us don't always get it right, you know, so it's
21 about helping to raise the quality because you equip people
22 with a culture of learning and resourcing their learning by
23 distilling the very large volume of research and theory
24 that's around into chunks that people can make sense of
25 quickly in the moment.
26
27 PRESIDENT NEAVE: Q. Can I ask about, you talk about
28 practice models and that goes, as I understand it, well
29 beyond sort of broad policies; it's really almost how to?
30 A. Yes.
31
32 Q. What do you do when you're talking to a child, what do
33 you do when you go to visit a child in the home, what do
34 you do when you're talking to, for example, a carer if
35 you're trying to work out what's happened. Have I got that
36 right? Have I understood what you've said?
37 A. Completely.
38
39 Q. So it's a much more sort of down to earth material
40 about what to do in certain situations, which is of course
41 supported by research. Have I got that right?
42 A. Correct, yes.
43
44 Q. Thank you.
45 A. And really it's not just the knowledge, it's how do
46 you translate that into the skill, how do you actually help
47 a mother, and particularly Child Protection who are obliged

1 to tell people that the information the family give may be
2 used, you know, taken to court within 24 hours, which
3 freezes. So, how do you actually use your warmth, your
4 humanity to get the foot in the door, help the family to
5 relax enough and help the children to feel safe enough to
6 talk to you: it's very sophisticated, important work.
7
8 So, you're right, it's not just the knowledge, it's
9 the practice, what we call the practice skills, and that's
10 around how you join with the family, how you build rapport
11 very quickly, and then develop a sense of engagement with
12 them around a shared purpose, whether it's one visit or
13 it's around your whole intervention with the family, what
14 are the goals, what are we on about, what's our joint
15 purpose for being here today, and also how can we help the
16 family with issues that we might not know about, so it's
17 around their needs and wellbeing, not just the immediate
18 risk.
19
20 MS ELLYARD: Q. Dr Miller, as I understand the answer
21 that you've given, the Best Interest Case Practice Model
22 doesn't just involve that kind of really practical detail
23 that the President has asked you about, it also assumes
24 supervision so that workers aren't just given this model
25 and told to apply it, they're continually supported and
26 given the opportunity perhaps to receive supervision and
27 reflection on their work; is that right?
28 A. And that's what we did, we built a whole team over
29 time where we brought in more skilled practitioners who had
30 clinical training, and by that I mean more specialised
31 therapeutic training around these skills that could
32 integrate the skills and the knowledge into these very
33 confronting frontline presentations. And so, a lot of
34 those people - there's often a division, sorry, I should
35 say, between Child Protection and mental health and then
36 the community services, and really you need all of those
37 therapeutic skills, I think, when you're working in Child
38 Protection to understand the complex dynamics in families.
39
40 So, I trained in family therapy which I find to be an
41 invaluable base; that was very complementary to social work
42 and psychology training that I did, but it was very much
43 around your practice skills and refining those, and that's
44 the training that we built with bringing in different
45 therapists who were also brave and able to deal with the
46 more confronting aspects of Child Protection work that you
47 don't have to necessarily deal with if you're in a clinical

1 setting like a hospital or mental health.
2
3 So, we built a team of what we call principal
4 practitioners who would provide what we called reflective
5 practice, and that is a more clinical case review, a team
6 approach where there's more time to reflect on the complex
7 work: what people are seeing, what they're feeling about
8 the work and what they're doing, and building that in a
9 more structured way is what we did in Victoria around -
10 throughout that decade and also building an operating
11 system where more experienced Child Protection
12 practitioners, instead of staying in the office as the
13 manager, would actually become - we built a system of
14 practice leadership so that each team would have a practice
15 lead as well as a team manager.
16
17 Q. And what was the impact as you observed it of this
18 approach on, firstly, I suppose the quality of the work
19 that people were able to do and secondly perhaps on issues
20 relating to staff wellbeing and retention given that this,
21 as we've heard, is a very difficult area of work?
22 A. We also brought in coaching and what we found at a
23 certain point was an improvement in the retention of
24 frontline practitioners. So, in Victoria there was a -
25 many of the managers had been there a long time, so there
26 was high level of retention, but it was the frontline that
27 there was a turnover and you're always going to get that to
28 a degree in nursing or teaching as well, but it was higher.
29 So, we were able to decrease the turnover, and I'm
30 confident that there was morale increased as well.
31
32 We also brought in a Graduate Diploma in Child and
33 Family Practice and we trained Child Protection, Family
34 Services and out-of-home care providers and Aboriginal
35 agency workers as well together in a group of 25 or so with
36 a consortia of universities, so it was paying people to
37 have that higher degree. So it was a Graduate Diploma, and
38 then we trained the supervisors in - sorry, it was a
39 Graduate Certificate in Child and Family Practice
40 Leadership, and then we trained a more senior cohort in
41 Child and Family Practice Leadership, and that was really
42 training them on how to be good supervisors; how to do live
43 supervision, go out on the most serious cases.
44
45 So my role in the department was really trying to
46 model and, because I did do the work with frontline
47 practitioners on the most complex cases, would go to court,

1 and that was quite unique that more senior Child Protection
2 managers generally - generally speaking, some would - but
3 generally didn't go to court. So, we were able to build a
4 greater sense of the expertise.
5
6 Q. Thank you. I wanted to turn but I'll pause in case
7 there's other questions, to ask you some questions arising
8 from your work at MacKillop, but were there any other
9 questions that any of the Commissioners had about the Best
10 Practice Model and the evidence that's been given about
11 that?
12
13 COMMISSIONER BROMFIELD: I didn't have a question on the
14 Best Practice Model, and I'll see, Ms Ellyard, if you get
15 to it but if we don't I wanted to ask some questions about
16 the engagement with Victoria Police.
17
18 MS ELLYARD: Yes, and I am certainly coming to that,
19 Commissioner Bromfield.
20
21 COMMISSIONER BROMFIELD: And I'll be quiet.
22
23 MS ELLYARD: Q. Dr Miller, you've indicated that the
24 role that you hold now is as the CEO of MacKillop Family
25 Services, and at paragraph 17 of your statement you
26 indicate the areas of work in which MacKillop is engaged
27 which, relevantly for the work of this Commission, include
28 children, youth and family and in particular, MacKillop is
29 a substantial provider of residential care services in
30 Victoria?
31 A. Yes.
32
33 Q. At paragraph 35 and following of your statement you
34 reflect on the evidence about the increased risk of child
35 sexual abuse for children in this high level cohort of
36 children in out-of-home and particularly residential care
37 and I wondered perhaps if you could speak to that.
38 Paragraphs 36 and 37, for example, speak to what is known
39 about the cohort of children who live in out-of-home care,
40 particularly residential care and what are the assumptions
41 that need to be built into any system that's going to be
42 caring for them?
43 A. Yes. Well, one of the first things I did at MacKillop
44 was start to think about prevention of sexual harm to
45 children in out-of-home care, particularly residential
46 care, and having spent 18 months at the National Royal
47 Commission on Institutional Responses to Child Sexual

1 Abuse, one of the great concerns was the greater risk for
2 children in residential care and indeed in any form of
3 out-of-home care of harmful sexual behaviours from other
4 young people or from sexual exploitation.
5
6 And part of my previous role as chief practitioner was
7 really leading greater teamwork with police and Child
8 Protection and agencies around identifying sexual
9 exploitation where adults are preying on young people in
10 care and there's some sort of exchange of gifts or money or
11 whatever to manipulate the young person, and this was a
12 huge problem.
13
14 So from 2007 I'd been involved in training and trying
15 to raise awareness of the harm and having a zero tolerance
16 approach rather than a harm minimisation approach, and the
17 Royal Commission did allow - there was a series of
18 roundtables and allowed the notion of sexual exploitation
19 to be a form of child sexual abuse, and where institutions
20 needed to be more proactive in preventing.
21
22 So coming then to MacKillop, with that experience and
23 fire in the belly really I was able to get some money from
24 our board to form a partnership with the University of
25 Melbourne to design and develop a pilot. We initially
26 called it Respecting Sexual Safety. The young people told
27 us that was a ridiculous name in no uncertain terms and
28 then the whole notion of power, the power how they trick -
29 how offenders can trick young people. A 14-year-old boy
30 was really articulate with me around the name and he talked
31 about how they take your power away because they trick you
32 and they make you think they're your friend and then later
33 you look back. So, this whole notion of Power to Kids
34 rather than power to the sneaky offender, so hence the
35 name.
36
37 Gemma McKibbin was the post doc researcher from the
38 University of Melbourne, we piloted it in four houses, so a
39 development and evaluation over four years, and I knew the
40 importance of having an evidence-based process and starting
41 to develop the evidence. You know, we call it
42 evidence-informed. To get the evidence-based tick you've
43 got to do a whole lot of other work and we're doing that,
44 the evaluation and research is ongoing. But I knew that
45 there was nothing else that had particularised a prevention
46 program for children. We'd done the international review
47 at the National Royal Commission, so it was, what can we

1 do?
2
3 And, you know, the duty of care that we have as
4 providers of care: if we say we do this work, we need to do
5 it as well as we can, and we know the problem, what are we
6 doing about it? So MacKillop has really embraced this and
7 we've now scaled it up to all of our houses. We have 65
8 homes in total, we've trained all of our staff, except for
9 the new people starting this week, I'm sure, but it's taken
10 time and effort to really insist upon that during COVID,
11 not allowing the barriers to get in the way.
12
13 And, not only that, we've trained all our directors
14 and managers, coordinators, therapeutic practitioners, so
15 we're all singing off the same song sheet.
16
17 Q. This is part of the Kids Program that you describe at
18 paragraph 46 and following of your statement, and as I
19 understand paragraph 48, Power to Kids has three distinct
20 although complementary prevention strategies and I want to
21 ask you briefly about each of them.
22
23 The first strategy is whole-of-house respectful
24 relationships and sexuality education. Can you tell us,
25 what does that mean in practice and what's its
26 significance?
27 A. What we know, and alongside the work around Power to
28 Kids we've also been doing deep dive case reviews and we
29 call that Outcomes 100. That name came from looking at,
30 what are the outcomes of our practice and how do we
31 improve? We did deep dive reviews, and 100 was the number
32 that we did, the first 100, because at that time MacKillop
33 had 100 young people, we've now got 153 in residence with
34 us. This started in June 2018, and I was already doing
35 consultations and reviews. What I said was, we need to do
36 this for every young person in residential care and do it
37 systematically, and what we gathered then was a very strong
38 database.
39
40 What we found was that there was a much higher
41 proportion of risk than what was realised when you
42 aggregate it. Subsequently - so that report was published
43 two years later in 2020, and then we've subsequently done
44 three other audits, and we now have a very strong three
45 time points to follow up the Outcomes 100 and the incidence
46 rates or the frequency, if you like, of the risk factors of
47 sexual abuse have remained relatively constant, so I have

1 much greater confidence in talking about the incidence of
2 the problem.
3
4 Q. The three prevention strategies, the first one is
5 respectful relationships and sexuality education?
6 A. Yes. So what we've found is that the incidence of
7 severe family violence was very high, somewhere between 80
8 and 90 per cent. So, the understanding of what is a
9 healthy relationship and the relationship dynamics was
10 really poor. The average number of placements was
11 somewhere between 10 and 20 placements, two of our kids had
12 had 56 placements before coming to MacKillop. Between 10
13 and 20, so the instability, and the pattern is generally
14 kinship, being passed to family members; foster care, that
15 will breakdown; then another foster care, that will
16 breakdown; respite care; foster care; maybe back to
17 kinship; then finally into residential care. So that whole
18 notion of trust is often lost, and the sort of embarrassing
19 conversations you'd have to have with kids around sex ed,
20 everybody thinks it's somebody else's job or they've got it
21 at school but the kids have missed a lot of school and
22 they've changed school.
23
24 What we've found, and we've known this for years in
25 the field, that the public agencies are very poor at sex
26 education and yet we've got adolescents growing, and of
27 course that's a big deal for adolescents that whole sexual
28 development and what is a relationship and what is a
29 healthy relationship. What does consent mean? What is
30 grooming? So, we go into that. So what we said, it's a
31 whole-of-house, so if you think of the triangle it's the
32 first sort of intervention, if you like, is that
33 whole-of-house education.
34
35 And we're targeting sexual exploitation, harmful
36 sexual behaviours and dating violence, and those three
37 problems are frequently presenting and they're frequently
38 connected and it's not surprising when you understand the
39 background of the children.
40
41 Q. Then the second element that you've described at
42 paragraph 48(b) is the missing from home strategy. Can you
43 talk to us about the significance of that strategy?
44 A. Yes. So, Barnardos Research in the UK, who were way
45 ahead of Australia in this field of sexual exploitation and
46 identifying risks and putting in place systems, identified
47 that missing from placement was a key red flag to - as an

1 indicator of sexual exploitation. And what we've said is,
2 the system can become way too desensitised to that notion
3 of kids - we used to say "absconding" but that's got a sort
4 of criminal tone to it, we don't say that, we say missing
5 from placement or away from home.
6
7 What we've done is broken that down. So, in the
8 audits now we do at MacKillop, we ask, are they missing
9 from placement and going to places that are not known? Are
10 they going out at night for short periods? Are they
11 associating with persons of interest? Or picked up by
12 unknown people in cars? Are they provided with gifts and
13 money by unknown people? So what we do is break it down
14 and so we ask much more detailed - you know, the better you
15 are at asking the right questions the more improved the
16 quality is of information.
17
18 So from all of our audits there have been 32, 33, 31,
19 32 per cent across the different time points have exhibited
20 harmful sexual behaviours at some point; that's young women
21 and young men, so it's roughly a little bit under a third.
22
23 The prevalence of intrafamilial abuse. In that first
24 cohort of 100 cases we found 48 per cent. But if you go to
25 the subsequent ones where we've just - we haven't collated
26 all the information from the panels, it's around
27 24 per cent, but we know it's much higher if you dig deeper
28 into their history, and that's child sexual abuse before
29 coming into care.
30
31 Q. Have you observed from the kind of careful audits that
32 you've been doing and the quite targeted questions to
33 reflect on about children's absence from placement, is that
34 work then reflected in a reduction in the number of
35 children who are absent from placement and exposed to harm?
36 A. Yes, yes. The way we use that information is to
37 absolutely target those young people with a much tighter
38 care plan, engagement, constant reviews, weekly reviews,
39 and we've halved the young people, that's our latest, that
40 are missing from placement. So, from where we started with
41 that first initial audit, we've halved that.
42
43 Part of what we found was that 43 per cent of young
44 people were known to have been a victim or at very high
45 risk of sexual exploitation before coming to MacKillop. At
46 the point where they're in MacKillop's care, and this was
47 the first Outcomes 100, so this is from 2020; that was

1 still the case for 22 per cent.
2
3 So, in one area, what we're doing now, we've continued
4 to innovate and try different things. We now have the
5 Director meeting weekly with the direct carers of those -
6 so in one area, in Victoria metro region, there were eight
7 young people regularly missing from placement, we've got it
8 down to four. And part of that is that the Director, much
9 more informed about the detail, will ring the head of Child
10 Protection in that area or ring a senior police person, and
11 so we're more able to get the nimble change and be more
12 interventionist in stopping that, or think about a circuit
13 breaker or take them away, or find that grandmother, or
14 what will motivate them to stay home? Maybe it is setting
15 up the sibling contact. Where's the brother that's 19 that
16 we haven't heard of, how do we find them? Where's the
17 money for brokerage dollars to take them out to buy new
18 clothes and actually create something for fun? So anything
19 that will build engagement and rapport. So, when we're
20 able to do that sort of creative work that you have to do
21 with young people, to give them a good enough reason to
22 begin to trust you, instead of wanting to go out and get
23 the $100 and the drugs from the offender.
24
25 Q. Then the third, and I want to ask you some questions
26 about the significance of - what you've just described is
27 really a multisystems response that isn't work just done by
28 MacKillop but work done by a range of agencies, but just to
29 finish off this question of the three prevention strategies
30 of Power to Kids. The third one you've identified is a
31 sexual safety response which I take it might itself include
32 a degree of multisystems responses?
33 A. It's absolutely based on a multisystem response,
34 that's correct. So, we can't do it on our own, we have to
35 have police involvement otherwise it's a tug-of-war, and
36 the Child Protection and non-government sector will lose
37 because offenders have enormous power and mobile phones
38 have made access to young people.
39
40 The online grooming actually increased during COVID.
41 And most young people will have an iPhone and offenders
42 will often give phones to kids, so the young people at
43 greatest risk will often have three or four phones and
44 we'll take them from them if they'll allow us but that's
45 often a vexed issue. The houses aren't locked, you know,
46 they're locked at night but young people - so we have to
47 use a power of relationship to try to stop them from going

1 out.
2
3 Police on the other hand and Child Protection have
4 greater powers. So, in Victoria Child Protection can issue
5 a harbouring notice or drive for an intervention order.
6 And, I've been absolutely involved in making that happen
7 both within my role in the department and at MacKillop.
8 We've been able to disrupt, with the help of police, the
9 offender from the grooming process.
10
11 And police, we call it disruptive policing, but it's
12 where the paradigm is around safety for the young person
13 and stopping the offender: you might not get a sworn
14 statement and a criminal conviction around the sex offence,
15 but you might well help this young person to have a very
16 different trajectory in life and keep them safe and get
17 them back to school, and we've been able to do that again
18 and again, but you need to have police at a local level who
19 will be supportive. Drugs are often involved, criminality
20 is often involved. There's different models for
21 understanding the technique of the offender, the dangerous
22 boyfriend, sometimes there is violence and sheer bullying
23 and harassment and the young person's terrified to get out
24 of it.
25
26 More often it's the sort of, the promise of attention
27 and, you know, party-party, and he loves me and, you know,
28 he might be 40 and have friends that he's manipulating the
29 young person to have sex with so, there's different forms
30 of it and it can be incredibly difficult for a young person
31 to trust a carer, so what we're saying to the carers in all
32 of those three strategies the whole skill base is around
33 brave conversations, and noticing and then initiating and
34 also sharing information with Child Protection and with the
35 police. So, residential carers will often have a number
36 plate, they'll often have a lot of information from the
37 other kids who will tell us what the one we're worried
38 about is doing; we'll often have names.
39
40 So the importance of Child Protection then having a
41 central network, a database, and police, is really
42 important because one area of Child Protection might be
43 looking after that particular geography but the offenders
44 go across geography and across regions. So, what we found
45 in Victoria in the department was the importance of a
46 template where we pulled together key information that was
47 held centrally. I was chief practitioner at the time, I

1 co-located two members of my team with the Sex Offender
2 Registry people, so we were able to all of a sudden put the
3 jigsaw puzzle together much more quickly to work out the
4 patterns and the networks of offenders because they would
5 often pass the names around.
6
7 Q. We're going to have a break in about five minutes,
8 Commissioners, because this is quite a long session. But
9 before we have that break, Dr Miller, you've touched there
10 in your answers not just about the significance of the
11 relationship between carers and the police but also about
12 the role of Child Protection.
13
14 At paragraph 21 and following of your statement you
15 gave some evidence about the proper balance or the sharing
16 of responsibility that works best in your view where a
17 child is subject to a Care and Protection Order that places
18 them in the guardianship of the department but is living
19 and being cared for day-to-day by a non-governmental
20 organisation. I'd be grateful if you could speak to those
21 paragraphs: what do you see as the proper balance of
22 responsibility, is there someone who always has to be in
23 charge? Where does responsibility ultimately sit for the
24 safety of children living with your organisation but whose
25 parent is the state?
26 A. I think the answer is both/and. The agency has a duty
27 of care to do everything you can and we take that very
28 seriously at MacKillop.
29
30 From a statutory point of view the case management
31 responsibility might sit with Child Protection, and any
32 child in residential care in Victoria is on a Child
33 Protection Order. Sometimes the case management is
34 contracted to the NGO and sometimes it's not, it sits with
35 Child Protection. Either way, though, Child Protection
36 would have what we call a contracting team that oversees,
37 has regular reporting in, and would do the court work, and
38 there's a different part of the department called the
39 Placement Coordination Unit, because residential homes are
40 state funded.
41
42 Agencies have so many "targets", they're called, and
43 there's often a very difficult process, where you know
44 somebody might be at risk even from another young person
45 within the home, so for example harmful sexual behaviours,
46 or the recruitment, they may not be acting out sexually
47 against that young person but they may be exposing them to

1 pornography or to this network of offenders, so you have
2 this contamination effect, if you like, between the peer
3 group within the home.
4
5 So, the importance then of, at times you might need to
6 change placement; that necessarily means a funding
7 discussion and where's another place? So, the department
8 are generally holding the funding of all the different
9 agencies who provide residential care and there's a wicked
10 demand problem and it's often incredibly complicated and
11 vexed and, you know, it can often feel like an impossible
12 situation to find the right placement and juggle the
13 competing needs of a group of young people.
14
15 So we advocate strongly the department do their very
16 best and, you know, there's funding issues where we want to
17 set up a contingency which is a one-to-one placement for a
18 young person, so there's a lot of dialogue and negotiation.
19
20 Q. One of the things you identify at paragraph 26 of your
21 statement is thinking back to the time that you were the
22 chief practitioner, was that sometimes if you were called
23 in to perhaps mediate a difference of opinion between a
24 provider and the department you would observe that perhaps
25 sitting at the bottom was lack of information, lack of good
26 data collection and sharing.
27 A. Often one of the - and this comes from international
28 research from Eileen Munro and many others who have written
29 internationally about Child Protection decision-making,
30 that heuristics operate - short quick decisions have to be
31 made, and what can happen is that people get on a train
32 track and think they know what's right and actually exclude
33 out conflicting information.
34
35 So the key point is to - is that professional
36 humility, that remains curious, remains open, and not
37 feeling like you've got to be the expert and that you're
38 initial risk assessment back in January is going to remain
39 the same in June, for example. But new information will
40 inevitably come to light, it didn't mean you got it wrong
41 back in January, it just means that you know more now.
42
43 So the risk in any sort of practice decision-making is
44 that you can go to one polarity or the other, that you'll
45 be overly optimistic, you'll look at the strengths in the
46 family, the protective factors, "Oh that'll be fine. No,
47 no, the grandmother's right, but we didn't factor in that

1 she's now got diabetes and actually the offending boyfriend
2 of the mother's is due out of jail". So, these - what we
3 call, you have your static risk factors but then the
4 dynamic risk factors, and you've got to be able to open up
5 and stay curious and revise, constantly review and update
6 your risk assessment.
7
8 MS ELLYARD: Thank you, Dr Miller. Could I invite the
9 Commission to stand down just for five minutes. This is
10 the halfway point in the session, just to give everyone a
11 break.
12
13 PRESIDENT NEAVE: Yes, we'll stand down for five minutes.
14
15 **SHORT ADJOURNMENT.**
16
17 MS ELLYARD: Thank you, Commissioners; thank you,
18 Dr Miller.
19
20 Q. Dr Miller, I understand that you heard just the end
21 section of the evidence of the witness before you,
22 Ms Lovell?
23 A. Very briefly, yes.
24
25 Q. One of the things that Ms Lovell gave some evidence
26 about in response to my questioning towards the end of her
27 evidence was about some observations that have been made to
28 the Commission about a cohort of children, perhaps aged 15
29 and above, who are without effective guardianship and might
30 be homeless or at risk of homelessness and whether or not
31 they were a cohort of children for whom there ought to be a
32 Child Protection response, and Ms Lovell's evidence was
33 that, although she saw a role for Child Protection she
34 didn't necessarily accept that placing a child of that age
35 on an order would do much to solve the problem of the risk
36 that the child was at, and I'm paraphrasing her evidence.
37
38 I'm interested in your perspective from the Victorian
39 context on the role that Child Protection can play perhaps
40 in the lives of older children who are starting to be
41 mobile and express their views and taking risks, and
42 whether there is a job for Child Protection in addition to
43 the work that might be done by other agencies?
44 A. I do think there is a role for Child Protection. I
45 think that Child Protection needs to be resourced to be
46 able to perform that role and the advantage is that -
47 because I agree that it can't be just Child Protection,

1 that that order of its own can be quite impotent.
2
3 The agency that is caring for the child is the one
4 forming the relationship. So, what we know from research
5 and from practice is that the key component of a good
6 outcome is the quality of that relationship, and the
7 ability for your carers to stay calm, to be non-judgmental,
8 to welcome them home even it is 3 in the morning and
9 they're substance affected, you know, to be non-blaming but
10 to be able to de-escalate violence, to withstand the anger,
11 the fight/flight response that comes from the past trauma,
12 and to stay with that warm approach that you matter and
13 it's our job to keep you safe.
14
15 And, not only that, to help you have a good life, and
16 what are you interested in, what's your schooling, what
17 TAFE, what can we get you, what apprenticeship, you know,
18 whatever it is that's going to create meaning.
19
20 So the agency has a huge role. The police absolutely
21 have a huge role, because obviously they've got the power
22 to work with the persons of concern or the offenders.
23 Together, you know, the system's saying the whole is
24 greater than the sum of its parts.
25
26 The role Child Protection plays in Victoria, and
27 indeed in New South Wales, we have 20 of our homes in New
28 South Wales and I'm very familiar with their Joint Protocol
29 and we're doing a lot of work with the police as well in
30 New South Wales who are very open to developing that
31 partnership.
32
33 The Child Protection advocacy is really important
34 together with the CEOs and the work that NGOs can do on
35 their own. Child Protection have that statewide remit so
36 there's more power, if you like, in the joined up advocacy
37 with police to try to work out the joint protocols to get
38 into each region's own response. So, it is that integrated
39 response that really makes a difference, and the research
40 in the family violence field is the same, the integrated
41 response, and the tipping point for change is when the
42 system works together.
43
44 And, as I said, Child Protection can initiate some
45 Children's Court proceedings where we were able to initiate
46 intervention orders. Children's Court magistrates were
47 very helpful with that, and police and Child Protection

1 together going to court on some of those civil orders had
2 greater potency.
3
4 So, it's not a simple answer; for me it's about the
5 both/and, and at 15 when they've had such trauma and, you
6 know, of our 153 children in residential care at the moment
7 roughly about 35 per cent live with disability; about
8 80 per cent, over 80 per cent have a diagnosed mental
9 illness. We're dealing with very, very traumatised young
10 people who've experienced horrors, you know, beyond most of
11 our knowing right at that crucial developmental age. So,
12 they might be 15 or 16 or 17, but they're completely behind
13 the 8-ball in terms of being able to discern who's a safe
14 person and they're entirely vulnerable to people who are
15 offering them the immediate gratification of money and
16 drugs.
17
18 Q. This raises a question which we've heard some evidence
19 about and I asked Ms Lovell to comment on it and we'll hear
20 more about it, the extent to which it does occur and, if it
21 occurs, whether it's appropriate to give children aged 15
22 and above the power to vote with their feet and to take the
23 view that they can self-protect by finding a place to live
24 so that they don't need to come into the out-of-home care
25 system or they can self-select to live away from placement
26 and their wishes should be respected. You've touched on
27 this in your statement but could you tell us your view
28 about that?
29 A. I would be very concerned about - I didn't, I wasn't
30 privy to all of the Director's evidence --
31
32 Q. Of course, yes.
33 A. -- so I don't want to comment on that particular
34 statement, but what I can say generally is that 15,
35 16-year-olds in our residential care homes with such
36 instability, such trauma, such complexity, if they're
37 missing from placement frequently, they're in trouble, and
38 frequently it is an offender. The research is in and our
39 practice evidence is in about that.
40
41 You know, I've personally been on a number of visits
42 where the brainwashing that occurs - I remember one young
43 woman screaming at me, "He's the only one that loves me".
44 And she was hiding, we were visiting the home, she was
45 hiding, he had put her in the roof. She was texting a
46 friend and one of the other friends told us that's where
47 she was so we got police to go in and that's where they

1 found her.
2
3 But it wasn't until we were able - and we had a secure
4 welfare capacity so we were able to - it's very difficult
5 to get children in, there's only ten beds in the state for
6 young women and ten for boys in Victoria, but a placement
7 there, where we were able to get the phone off her. She
8 was able to be detoxed. She had a sexually transmitted
9 disease, which is a real issue for kids. There were, you
10 know, all sorts of medical problems with her as well. But
11 it wasn't until we were able to detox and then absolutely
12 flood her with warmth, with engagement, withstand her anger
13 and vitriol, and then gradually bring in some key people -
14 for her it was her grandmother - and we were able to begin
15 to - and she herself later said, "I think I got caught up
16 in a cult". Now, it wasn't a cult, he just brainwashed her
17 like offenders do. But he'd groomed her to such a degree,
18 and he was fuelling her with drugs which was - you know.
19
20 PRESIDENT NEAVE: Q. So, the points that you've made in
21 favour of orders are the ability to do things like call in
22 the police which then means you can intervene in those
23 other ways and the ability to detect people who are doing
24 this in a systematic way around the state, which if you do
25 it all on the basis of a sort of voluntary basis, you can't
26 do it. Have I understood you correctly?
27 A. Correct. You can't aggregate up the knowledge around
28 offenders and networks. Even Child Protection couldn't if
29 they were just working regionally, which is what used to
30 happen. What I was able to do was to advocate and say, we
31 need a central database.
32
33 Q. Yes.
34 A. And collocating Child Protection senior people who had
35 that central - the templates would come in from all the
36 regions to one spot, and then we're able to correlate, hang
37 on, that name came up in the east and he's also actually in
38 Warrnambool. Then we were able to work out - the kids were
39 on the train lines. Some offenders were giving kids
40 E-tickets from Tassie actually or from Sydney. So, they
41 would give the kids on a phone the E-ticket and they were
42 getting on planes to be exploited. Shocking stuff. So, it
43 happens and what we were saying is, zero tolerance, we
44 needed police to help us intervene, but as an agency caring
45 for a young person, unless you were very strong you
46 wouldn't have access to that level of advocacy or to the
47 joined up intelligence.

1
2 COMMISSIONER BROMFIELD: Q. And it sounds like the
3 secure welfare placements were a last resort but an
4 important component of your toolkit of responses to combat
5 that brainwashing when the young person really couldn't be
6 separated from the person exploiting them?
7 A. Correct, yes. So that, the opportunity to have a
8 contained, safe environment - what we found interestingly
9 young people relaxed and you often then saw the little girl
10 who wanted to cuddle up with a soft toy, who might have
11 been, you know, swearing and acting like a 30-year-old when
12 she's 15 out in the world, you know, rejecting the
13 placement, running amok, if you like, but with offenders
14 pulling the strings. And often saying, "Bring your mate.
15 I need your friend. What's the matter, you didn't bring
16 your friend?" So what we need to understand is the
17 recruitment of other young people in care, that happens.
18
19 The other side of that is, young people putting
20 themselves on apps, on these mobile phones, you know, one's
21 called Grindr, there's a range of them, where they've
22 learnt to - you know, I can make a sort of sex video, I can
23 do this or do that and get money, and the money's generally
24 for drugs or for clothes or whatever, you know.
25
26 So, it's a complex dynamic where the young person is
27 not trusting any adult in their life, and I have learnt and
28 been manipulated that I can do this and I can get money and
29 I'm in charge. So, the dynamics of it psychologically are
30 often around a re-enactment of trauma. You know, as a
31 little kid they were done to, they were victimised, now I'm
32 going to be in charge, I'm the boss. That's another whole
33 complex area.
34
35 MS ELLYARD: Q. Perhaps picking up on that, can I ask
36 you about, some of the materials that are going to be
37 considered this week relate to the risks of harmful sexual
38 behaviour and the risks that some young people might pose
39 to other young people in placements.
40 A. Yes.
41
42 Q. And the question of how decisions can be made about
43 placements that will serve the interests of highly complex
44 young people, and I'm conscious that you may have some
45 reflections from your experience at MacKillop on the way in
46 which to plan for placements and the placement of children
47 in homes where they're not going to be vulnerable to

1 exploitation from other children.
2 A. And look, this really relies on your staff being
3 trained and attuned and well supported, well supervised.
4 What we've found is that there was a difference in the
5 funding models, that about a third of the placements were
6 considered therapeutic, would have extra funding for a
7 therapist to be attached to that home, which is up to four
8 young people being housed together with rotating staff on a
9 roster; so that's what we mean by residential care.
10 Sometimes the homes are two-bed and we've advocated and we
11 have now more two-bed and sometimes with extreme behaviours
12 the department will fund one young person, it's often
13 called a contingency or an unfunded placement. It's
14 because things are so serious that's the only way, or
15 they've harmed other young people in care so it's too great
16 a risk and it can't be managed.
17
18 COMMISSIONER BENJAMIN: Q. It sounds like you've got
19 pretty good triage facilities there. You talked about that
20 central point so that people who knew what they were doing,
21 whether it's police, Child Protection, NGO, and presumably
22 the courts are also informed courts in Victoria, aren't
23 they - and I'm not critical of the local courts, but
24 they're specialist Children's Court, aren't they?
25 A. They are, the Children's Court is considered a
26 specialist court and those magistrates hear those matters.
27
28 Q. Then you've got the secure welfare facility, with a
29 limited number of beds, but you can focus significant
30 resources on those particular children with their
31 particular problem?
32 A. Yes.
33
34 Q. And then, once you get over the hump, you can then
35 send them down, or send them across - send them down is the
36 wrong word - but send them across to trained staff in not
37 so intense facilities but let it go from there. Is that
38 what you're saying?
39 A. That's right. So partly it's the more complex the
40 young people - and really there's no difference, what all
41 our research from MacKillop has shown, that there is no
42 difference in the complexity and the needs and problems of
43 the young people in the therapeutically funded homes
44 compared to the standard residential homes; that in fact
45 there was no difference. So, we've been advocating
46 strongly for a pricing review of the residential care
47 funding, because the staffing - to get the staffing and the

1 supports. So, MacKillop has actually self-funded
2 therapeutic support for every home now and that has meant a
3 greater awareness of - and we've increased the training
4 dramatically. So the supervision, we're much stricter, the
5 training, but you've still got a turnover so you can never
6 say, you know, it's always a dynamic that - you know, and
7 new information will come to the surface that you might not
8 have known when the young person was referred into that
9 particular residential home.
10
11 Q. And the exquisite trauma that these young people go
12 through is just - I can't think of any circumstance where a
13 child would be in out-of-home care where there wasn't some
14 significant trauma in the background. I've struggled to
15 imagine a case where there wasn't trauma?
16 A. Absolutely, Commissioner, they've all had horrific
17 trauma. Not only that, the loss and grief of lost parents,
18 lost siblings.
19
20 Q. That's a significant trauma in itself?
21 A. Absolutely. Lost places that they loved or, you know,
22 they might have loved a particular school, a teacher, you
23 know, a pet they've left. So, when they're taken into
24 care - and the courts have a very high threshold around the
25 risk that needs - you know, there needs to be - Child
26 Protection, most children involved in Child Protection stay
27 at home, of course, and Child Protection does a lot of
28 unrecognised work to support families, and so, it's only a
29 very small percentage actually end up in out-of-home care.
30 So, things are very serious to get to that level.
31
32 Q. We heard some fairly poignant evidence this morning
33 about a child who was removed but all of her possessions
34 were left behind and the impact on her of the loss of those
35 possessions which to some it wasn't much but for her it was
36 huge because that was all she had.
37 A. Part of that healing from trauma is to form what we
38 call a - have a coherent understanding of why I'm in care
39 and what happened, and why my mum couldn't or why my dad,
40 and where are my things, where are my photos? So part of
41 what we've done as an agency is trained about a thousand of
42 our workers in what we call therapeutic life story work.
43 So, what we've done is a number of different things to try
44 to skill up the carers so that we can be more helpful and
45 more compassionate to the needs of young people and not get
46 caught up in reacting to the aggression that's usually
47 there at the beginning; you know, the kids come in with a

1 pretty tough sort of fight response, fight/flight, and
2 that's a trauma response; they're wired to survive so
3 they're running on adrenaline, so they're easily triggered,
4 so we have to have staff that aren't reactive to that, you
5 know, they don't know how to stay calm, dinner's going to
6 be on the table at six; we really care about you; oh, you
7 like getting your nails done, what can we find, so some way
8 to engage and have some warmth so you can begin then to
9 turn it around.
10
11 I was in Sydney on Friday and two girls I lost sleep
12 over seriously, two of our girls in Sydney, sexual
13 exploitation and drug taking: one of them's got a job now
14 she's very proud about and she got employee of the week at
15 Hungry Jacks, and the other one is back at school, had her
16 school uniform on, we had a recon - so, you know, it is
17 possible with really warm, resilient, down-to-earth staff
18 that will go the extra mile; but that means you've got to
19 support those staff, you know, if they're injured or the
20 victim of that aggression, and how do you help them to do
21 the repair work. So, we train everybody in therapeutic
22 life crisis intervention, TCI, which is, how do you
23 de-escalate, how do you use your body, how do you not raise
24 your own voice, how do you stay calm, how do you not get in
25 their space, how do you prevent the violence occurring?
26
27 It's a very skilled, sophisticated body of work. Good
28 quality therapeutic work is extraordinarily complex, I
29 think they deserve a medal.
30
31 Q. And for the kids there is an opportunity, a chance?
32 A. And the kids love them and they'll come back, yeah.
33 We have community meetings, house meetings. Many of the
34 kids have never learnt to sit at a table to have a meal
35 together, the meal table's been a war zone, you know. So,
36 helping them bit by bit understand that you can create a
37 safe place. So, the Sanctuary Model is something we train
38 everybody in that helps everybody at MacKillop, even the
39 gardeners and the guys doing the finance to understand
40 trauma and why the kids will smash the car occasionally,
41 you know. So that question of what's happened to them
42 rather than what's wrong with them and how bad they are.
43 You know, let's have a compassionate understanding, what's
44 happened to them. But not just understand but actually,
45 how do we intervene to turn it around to change things?
46
47 COMMISSIONER BROMFIELD: Q. Dr Miller, can you remind me

1 again what year you became the CEO of MacKillop?
2 A. 2006.
3
4 Q. 2006? 2016?
5 A. Sorry '16. I'm going mad. 2016.
6
7 Q. So, 2016, and are these all things that you've
8 implemented in your term as CEO?
9 A. The Sanctuary Model was already at MacKillop. So, the
10 previous CEO did a marvellous job and had embraced the
11 Sanctuary Model since 2012. So that whole notion of - we
12 had - the department brought in the Sanctuary Model in 2008
13 and I was part of that, and it was something that attracted
14 me to go to MacKillop, because I knew they had already
15 embraced that trauma-informed practice.
16
17 The therapeutic crisis intervention, the power to
18 kids, the therapeutic life story work, HEALing Matters, all
19 these other things were brought in subsequently, and the
20 principled practice - we've, you know, got a staff of about
21 30 now, clinical people. That's all grown as we've
22 realised the need for it, and the board have accepted my
23 recommendations and we've found ways to fund it.
24
25 Q. Can I just check: in Victoria, would you consider
26 overwhelming demand and shortage of appropriately qualified
27 workforce to be a challenge?
28 A. Overwhelming demand, absolutely. Workforce is
29 absolutely an issue for every agency. And it's not just
30 recruitment, it's retention. Occupational violence in
31 residential care is a big issue, and we've worked very hard
32 to reduce that and to support staff who may be injured
33 psychologically or physically.
34
35 So, we've introduced evidence-based things in the last
36 five years called EMDR, Eye Movement Desensitisation
37 Reprocessing, so we're doing that with our staff, which has
38 had a real impact and helping them to have more skilled
39 intervention at the point after an assault or after an
40 episode where things have blown up to help them to not be
41 injured by that and just come back to work the next day.
42
43 The importance of having - when we say
44 "trauma-informed", it means you're actually using a range
45 of different strategies to help your workforce to stay in
46 the work.
47

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1 Q. The reason I asked these questions is, it can be easy
2 when you're listening to someone who's gotten a long way
3 advanced in a journey to think, "Well, I'm all the way back
4 here. How can I ever get to there? It's too hard, you
5 don't understand how hard it is." I just wondered if you
6 had any reflections that you might offer on how you
7 implement to actually see change at the frontline, how you
8 create the space to be able to do this work when you're
9 dealing with overwhelming demand and workforce shortages
10 and critical incidents and all the things that come with
11 working in out-of-home care?
12 A. One staffing group, one child at a time. And that's
13 why the importance of those deep dive case reviews, the
14 importance of training, the importance of not just
15 supervision but group reflective practice. So it's a range
16 of things. The focus on work health and safety.
17
18 MacKillop have an institute where we've received
19 funding philanthropically to offer Power to Kids, the
20 prevention program, nationally. We've now got 14 agencies
21 and we were - South Australia were very much - highly
22 motivated to improve the quality and safety of residential
23 care, didn't have the funding around the clinical support.
24 We've been training them in the Sanctuary Model, which
25 they've really embraced: they're seeing change. Similarly,
26 we're training all of their residential care homes and
27 teams in the Power to Kids. So, that's a system that's
28 embraced it. We've actually had some enquiries from
29 Tasmania, which we're certainly supportive of providing.
30
31 So that, I think it's about taking step 1, step 2,
32 step 3. And local people on the ground have the best
33 ideas; it's not all top-down. You know, it's really
34 engaging people that are closest to the kids and their
35 families.
36
37 The big thing, too, is making it culturally safe, so
38 for Aboriginal young people or children from culturally and
39 linguistically diverse groups to really - we've tried to
40 very much tailor it to the individual cultural norms:
41 that's the Power to Kids and Sanctuary. Cultural safety is
42 one of the pillars.
43
44 So, there's no one magic bullet, but you start
45 somewhere. And there's a lot of goodwill from the staff
46 that I'm sure are on the ground right now, and it's about
47 working together to work out the first step, or the next

1 step. And part of it, can I say, is about resourcing: you
2 do need funding to develop the training and the positions
3 so that you have the clinical and the operational like this
4 (indicates) hand-in-glove, rather than a consultant once a
5 month saying, "You ought to do that", and the staff saying
6 "Well, you come and live my life," you know, "and try to
7 answer the phone, cook the tea and have a therapeutic
8 conversation and write the notes." It's really hard.
9
10 So it's about understanding deeply what the work is in
11 out-of-home care, residential care. But also foster care;
12 we haven't talked about that. But we've trained up our
13 carers in the Power to Kids, and they're really clear that
14 they lacked information on the brave conversations and how
15 do you talk to kids about the eSafety, the online grooming,
16 and how do we talk about consent? So, all of these things
17 really - foster careers need it, too.
18
19 MS ELLYARD: Q. Could I perhaps ask a question,
20 Dr Miller, which invites you to reflect on the basis of
21 your recent experience at the department as well as your
22 current experience at MacKillop. You've talked about
23 change perhaps one child at a time. Some of the evidence
24 that we have in this week is that there's been a constant
25 process of change in the Child Safety Service in Tasmania,
26 constant reviews, constant new models coming out and on one
27 view the change literally has never stopped so that any
28 document isn't in place very long before it's subject to
29 potential change.
30
31 Now, of course there should always be improvement, but
32 I'd be grateful for your reflection on how one balances
33 improvement with some kind of stability for the workforce
34 and for the children who are being cared for by the
35 workforce?
36 A. I think part of it is celebrating and noticing the
37 good practice. The media love a salacious story, but
38 wouldn't it be lovely to have a profile on the front
39 page of the change that child protection workers are doing
40 today in Launceston or Burnie, or - you know, the
41 difference they're making. Because they are. So noticing
42 the strengths, noticing the brave, amazing practice that is
43 on foot today - I'm sure it is - and then you build morale
44 and you get good people wanting to stay in the work.
45
46 How do you actually get sophisticated supervision that
47 is noticing and is able to do the family - and notice the

1 family's strengths without being punitive and
2 mother-blaming, understanding the impact of the mother's
3 experience of family violence on her parenting capacity;
4 are we at the point where she just can't do it or actually
5 if we put enough supports into the family - so how do - you
6 know, you can't just fund child protection as a system; you
7 need to be able to fund your family supports adequately,
8 and train those workers who can regularly do the work to
9 support the family so that they don't need the statutory
10 order anymore.
11
12 So you then also then need to work out, how do you get
13 your children that are in out-of-home care back home?
14 Because an awful lot of kids can go home, if we worked
15 enough, not in having the battle in court around the
16 conditions of the court order, but actually in getting a
17 conciliation and getting the parents to understand, okay,
18 what are the goals, what do I need to do to get that kid
19 home? Because we know from that first six months that the
20 children are in care, that's your best shot at getting them
21 home. If you can engage the family, that's where the
22 motivation is.
23
24 So if you think systemically, you can't just think
25 about funding child protection or residential care; you've
26 got to think about funding your whole system and also
27 training people at TAFEs and universities to want to do the
28 work, and that means raising the morale and the profile and
29 having a greater community respect for those heroic people
30 who do it day-in and day-out.
31
32 Q. And so, in the context of Tasmania where, on the
33 evidence that I understand the Secretary will give later
34 this week as foreshadowed in his witness statement, where
35 there's a very large number of pieces of work in train, no
36 doubt all with good intention, but one could imagine that
37 the net effect is that those doing the work as Child Safety
38 Officers and in the foster care system have a degree of
39 uncertainty about what the rules are and what the guides
40 are and how they should conduct themselves. I'd be
41 grateful for any comments you have on, again, how to
42 balance that, the need for reform which may well be
43 necessary, with the need for some kind of predictability
44 and stability in the system?
45 A. I think the more regulatory and - so, it's a very
46 delicate balance, because you want to raise a standard.
47 The young people and families have been harmed to such

1 a degree, and the children need to be given best practice.
2 To do that, you've got to have your smartest and your
3 brightest and your most compassionate skilled workers stay
4 in the work and model how to do it. Because you can have
5 all the training and read all the books, actually doing it
6 in practice is the real skill. And people learn, actually,
7 most from watching and seeing and doing it with. So, the
8 role plays that you do at uni and all of that, yes, but the
9 actual sort of practice experience is what makes a
10 difference.
11
12 So we, for example, in residential care we shadow
13 shift people. We've now got therapeutic trainers that go
14 into houses, you know, where we've got really troubled
15 times happening, and model, how do you do this. And
16 getting the directors in. So, I talk about visible
17 leadership. So, the whole shift in Victoria was actually
18 saying, your most experienced people need to be nipping in
19 the bud the problems. Rather than dealing with complaints
20 in the office and being office-based, get out and do the
21 hard yards frontline for your most complex cases or where
22 you've got recidivist issues happening.
23
24 So, I strongly believe that that makes a difference
25 and relieves some of the anxiety of new graduates who can
26 then become more rigid in their thinking because they're so
27 anxious about getting it wrong. So, if you don't have a
28 period of consolidation - and I know that other states are
29 talking about this as well. There's been so many
30 enquiries, so many recommendations, it's overwhelming the
31 system. And often, the funding isn't commensurate with the
32 expectations. And they're getting, damned if you do and
33 damned if you don't. "You're stupid you didn't take that
34 child; you should have known." But then, "Oh, you're
35 taking the children." You know? "You're kidnapping the
36 kids." So, this sort of polarity around how Child
37 Protection is viewed is really very difficult, and Child
38 Protection practitioners, by and large they're human rights
39 workers. You know? They're going out because they
40 strongly believe children have rights to be safe. And
41 people can be Pollyanna about families, but horrific
42 cruelty happens in families and we're naive if we think
43 that it doesn't. Equally, most families don't want to hurt
44 kids. Most children belong back in the family.
45
46 So overwhelming the child protection system with every
47 child wellbeing issue is not going to get a system

1 anywhere. So building up your family support structures so
2 that they can be proactive and engage with the
3 difficult-to-engage families is a really important part of
4 how you keep children as a community safe and thriving.
5
6 So, it's almost like that notion of "child protection
7 is everyone's business". So what happened in Victoria was
8 training up the Family Services sector in risk assessment;
9 that was really important. And saying, "Actually you can
10 carry a whole lot more risk." And that has happened, so
11 that whole child first development of a joined-up intake in
12 getting the child family support services to share an
13 intake to talk to each other in local areas, so you have
14 more of an area-based system, more along the UK lines of a
15 local authority system, you know, where you have an area.
16 And so, police are part of that as well, with the sexual
17 abuse issues.
18
19 Q. The Commission's received some evidence or reflections
20 from some non-governmental organisations who I think would
21 say that they find the idea of sharing in the risk
22 challenging, that they have a concern that risks that are
23 at a level that ought to sit with Child Safety Services are
24 being shared or pushed back on them. As I understand it,
25 in your view it is possible for some risks to be shared as
26 between Child Protection Services and other community
27 organisations?
28 A. It's not only possible, it's absolutely necessary.
29 You shouldn't have Child Protection as the narrow eye in
30 the needle that families that really need the most
31 intensive support have to come via child protection. What
32 we developed was a community-based response, and
33 community-based child protection workers who could do some
34 of the more complex cases where you are, you know, "Are we
35 on the cusp?", "Is it too dangerous?" You know, what other
36 protective factors are not necessarily the strengths in the
37 family. The strengths might be the mother loves the
38 children, but the risk factor and the likelihood of harm
39 are so strong that that's overwhelmed, you know? So, the
40 complexity of that risk assessment, you need to be
41 consulting and have that fresh information. So, there
42 might not have been a charge for the family violence, but
43 there might have been 10 police call-outs, yeah, that
44 didn't result in a charge. Well, those 10 police call-outs
45 are really important information for the experience of the
46 children.
47

1 And, you know, families aren't always forthcoming
2 about the truth of the matter, so kids can be exposed to
3 horrific stuff, and if there's drugs. So that whole sort
4 of nuance where Family Services might be involved, but
5 actually the parents aren't engaging; there's no evidence
6 of change. And that's been over a period of time; you've
7 got a baby there, you've got children, you know? You need
8 to have the capacity of the community service agency to
9 have Child Protection jointly visit with you and help with
10 that very complex decision-making.
11
12 If you have everything through Child Protection, it's
13 an unnecessary overwhelming of the statutory system so that
14 the most forensically dangerous cases don't get the
15 attention because the whole system's swamped by wellbeing
16 cases that could be dealt with by community services.
17
18 Q. The last question that I wanted to ask, Dr Miller, is
19 to revert back to the question that Commissioner Bromfield
20 flagged and that you've already touched on, which is the
21 way in which foster care providers and residential care
22 providers can partner with police to disrupt sexual
23 offenders. I'm aware that you have some experience with
24 this both while you were a principal practitioner in the
25 department and more recently in Geelong, I think, in part
26 of your work with MacKillop. I'd be grateful if you could
27 explain to us how in practice that partnership between
28 MacKillop and the police operated, and the changing mindset
29 that perhaps was involved for police?
30 A. Absolutely. We were able over a period of three
31 years, through that partnership work, the joint, work,
32 which is ongoing, but it was a particular police sergeant
33 who was fantastic, who absolutely respected the work of the
34 residential care providers, you know, the carers. And
35 there was a network of drug-dealing, sex-offending parents,
36 actually, who were then recruiting kids. They lived - the
37 houses were in close proximity. Over a period of three and
38 a half years, there were 14 offenders that were remanded,
39 which is quite extraordinary.
40
41 So the paradigm shift with policing was around helping
42 the kids to be safe rather than getting a criminal
43 conviction for the sex offending. What we found, though,
44 was actually both were achieved through that joined up work
45 with Child Protection as well. And in Child Protection,
46 what we've done is develop over the years a sexual
47 exploitation Practice Leader in each area. So, someone who

1 had that portfolio, who was training up new child
2 protection workers, who held the overarching dataset, who
3 was liaising with the sex offender unit. So those
4 positions still exist. So they operated out of the office
5 of professional practice that I headed up and they still
6 remain in place operationally around Victoria, and that
7 expertise that we recognised was needed in each area. So,
8 in Geelong that Practice Leader in Child Protection was
9 terrific as well. So that you had the trifecta: You had
10 the Child Protection, the police and the agencies working
11 like this (indicates).
12
13 Q. In practice, as I understand, it in the end it did
14 result in a number of criminal convictions or remands,
15 which presumably meant that children made statements and
16 gave evidence?
17 A. They did.
18
19 Q. But it didn't start with the aim of getting evidence
20 from children?
21 A. No. So the old days was police would say, "Look, come
22 back if she's prepared or he's prepared," because boys get
23 sexually exploited as well, and that's often even further
24 underground. The frequent response we used to get was, "Is
25 he or she prepared to make a sworn statement?" "No?
26 Well" - and they're usually not - "Call us when they are."
27 Which meant NFA, no further action. What we are able to do
28 is say, "Look, they might if we're able to build rapport,"
29 or, "If we could get you to" - you know, "we know he's
30 driving an unregistered car. There's unpaid fines."
31 Police would do the old knock on the door, the disruptive
32 policing, so there was often - and then bit by bit, we'd
33 come to - you know, we'd have police every week coming to
34 our homes for dinner in plain clothes, shooting hoops with
35 the kids. We got them to come on camps with the kids.
36 They do a whole lot, so they build a relationship, build a
37 rapport. It's surprising how quickly the kids will talk if
38 they trust the person. And they might talk then because
39 they don't want that friend getting into the same trouble.
40
41 So the camaraderie and partnership between the three
42 systems is so important, and then of course getting
43 education involved so that the kids aren't excluded from
44 school because of bad behaviour, but how do we get them
45 back into a positive trajectory, get them a part-time job?
46 All of these things matter as well. The mentoring
47 programme for Aboriginal kids. So, it's not just one thing

1 or even the three systems; you've got to think
2 holistically. And often, the leverage for change was the
3 family.
4
5 The other thing I just wanted to add, going back to
6 the previous question you asked me about the system, we had
7 a program and have a program called Cradle to Kinder, it's
8 now called Family Restoration and Preservation, in
9 Victoria. The department in Victoria and South Australia
10 collected the data around unborn Child Protection reports,
11 found that within one or two years, 28 per cent of those
12 reports ended up in care, those babies: 28 per cent.
13
14 We were funded to do outreach in three different areas
15 initially, now nine different areas, to have an integrated
16 casework and therapeutic - family counselling and casework
17 together outreach, not expecting them to come into our
18 office, but we go out. So I talk about, you know, family
19 therapy around the kitchen table or in the car while you're
20 getting the child immunised and finding the birth
21 certificate and helping mum to get the confidence to go to
22 the doctor to get a GP referral to get the depression
23 treated. You know? It's that sort of thinking
24 holistically about what's getting in the way of the good
25 parenting.
26
27 Over four years, we were able to reduce that figure to
28 11 per cent. That's why I'm so passionate about the need
29 to think holistically about the system.
30
31 Q. And to start as early on as possible in the life of
32 the child who might otherwise be at risk?
33 A. Absolutely.
34
35 MS ELLYARD: Thank you, Dr Miller. Thank you,
36 Commissioners. I'm looking at the time but if there are
37 any questions for Dr Miller?
38
39 PRESIDENT NEAVE: Q. I just have one quick question. We
40 are going to be looking at youth detention, I wonder
41 whether MacKillop has had anything to do with dealing with
42 kids who are already in the system, you know, in the youth
43 detention centre. We might want to find out some
44 information about that, about you applying the principles
45 that you've talked about in that context?
46 A. Yes, we absolutely do. We run a programme called
47 Multi-Systemic Therapy psychiatry, MST. Again, that's

1 about having the trained people, well-supervised, smaller
2 caseloads, working outreach intensively around the family,
3 intensively for six months, with mental health embedded in
4 the team, a psychiatrist embedded in one day.
5
6 I can give you the statistics, but the police - one of
7 the criteria for entry into that program is, you know, at
8 the pointy end. Kids that are involved in criminal
9 networks, guns, knives, what have you, and complex mental
10 health. And we've been able to reduce between 80 and
11 90 per cent no new arrests; between 90 and 100 per cent
12 after six months at home. So, some of those kids started
13 in residential care. But what often happens, when they go
14 home there's no support for the family. So it all - the
15 merry-go-round starts again. What this was, was an
16 intensive intervention to support the parents and the kid
17 and the school and the siblings and the next door
18 neighbour - whoever is relevant to the family - to do the
19 work to understand what the pain is about, what the rage is
20 about, and how do we actually get them onto a different
21 trajectory. That's very skilled work, but it's possible.
22
23 PRESIDENT NEAVE: Thank you.
24
25 COMMISSIONER BROMFIELD: Q. I had a final question, too,
26 and thank you for your evidence. You've talked about the
27 need for therapeutic care. You've talked about it from a
28 human rights perspective. You've been doing it; I wonder
29 if you had any reflection at all as to whether there's any
30 cost benefit to providing therapeutic care?
31 A. Absolutely. If you think about the cost when young
32 people leave care, we know that the system down the track
33 will be paying for it anyway in terms of police, emergency
34 health services, mental health services. You know, we've
35 got philanthropic money also to run adolescent violence
36 programs because of the increased risk of becoming a
37 violent offender down the track. So it absolutely pays
38 off.
39
40 The targeted intervention for children with harmful
41 sexual behaviours, the evidence is in: most young people
42 don't go on to adult offending. But if you look the other
43 way, adult sex offenders, most of it started in
44 adolescence, yeah? So, the intervention works. It's about
45 skilling up, training the right people, supporting them to
46 stay in the work, so there's absolutely - and there's many
47 different ratios, but if you spend $1 - the Heckman

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1 Equation: if you spend $1, you save $17, I think it is,
2 down the lifetime. So there's very different ratios that
3 very clever economists have come up with, but I think
4 unequivocally the evidence is in: if you invest early, you
5 will save money. The state will save money. So, even if
6 you didn't care about the people and the children, you just
7 cared about balancing the books, it's smart economics.
8
9 COMMISSIONER BROMFIELD: Thank you.
10
11 MS ELLYARD: Thank you, Commissioners, I ask that
12 Dr Miller be excused.
13
14 PRESIDENT NEAVE: Thank you so much, Dr Miller. That was
15 really very, very helpful. We'll take a 20 minute break.
16
17 MS ELLYARD: As the Commission please.
18
19 **SHORT ADJOURNMENT**
20
21 PRESIDENT NEAVE: Thank you, Ms Darcey.
22
23 MS DARCEY: Yes. Thank you, Commissioners. Our final
24 session today is a panel of two members from the Foster and
25 Kinship Carers Association or FKAT for short, Dr Kim
26 Backhouse and Dr Julian Watchorn. If Dr Backhouse could be
27 called first, she'll take an oath.
28
29 **<KIM MARIE BACKHOUSE, sworn:** **[3.28pm]**
30
31 **<JULIAN HUXLEY WATCHORN, affirmed:**
32
33 **<EXAMINATION BY MS DARCEY:**
34
35 MS DARCEY: Thank you. And if I could start with you,
36 Dr Backhouse. Would you tell the Commissioners, please,
37 your full name?
38
39 DR BACKHOUSE: Kim Marie Backhouse.
40
41 MS DARCEY: And your current occupation?
42
43 DR BACKHOUSE: Part-time CEO at the Foster and Kinship
44 Carers Association.
45
46 MS DARCEY: And Dr Backhouse, is it the case that you've
47 provided a statement which you affirmed on 8 June 2022 for

1 the assistance of the Commission?
2
3 DR BACKHOUSE: Yes, that is correct.
4
5 MS DARCEY: Do you have a copy of that statement in front
6 of you?
7
8 DR BACKHOUSE: Yes, I do.
9
10 MS DARCEY: Are you satisfied this the contents of that
11 document is true and correct?
12
13 DR BACKHOUSE: Yes, I am satisfied.
14
15 MS DARCEY: Dr Backhouse, in that statement at
16 paragraphs 3 and 4 and then later at 12 and 16 you outline
17 your qualifications and background. Would you mind
18 providing us with a summary of those qualifications and
19 background for the Commissioners?
20
21 DR BACKHOUSE: Sure. You?
22
23 MS DARCEY: Where you like. Just look at me, perhaps, and
24 then you can - thank you.
25
26 DR BACKHOUSE: Yes, by way of background, I have a
27 bachelor of laws from the University of Tasmania; a masters
28 of business administration from the University of Tasmania,
29 that was part of a consortium of Australian management
30 schools at the time; I have a diploma from the Australian
31 Institute of Company Directors; I have a doctorate of
32 philosophy with corporate governance, innovation and
33 superannuation as the theme there; and more recently I have
34 an honours masters of employment and labour law from the
35 University of Melbourne.
36
37 MS DARCEY: Thank you. In terms of the different roles
38 you've held throughout your career, which I think you'll
39 find at paragraphs 12 to 16 of your statement, are you able
40 to detail some of that for us, please?
41
42 DR BACKHOUSE: Yes. Obviously, I don't mention everything
43 in there because I've worked in top tier law firms in
44 Melbourne and had other roles, but just for the purposes of
45 currency, I've been an academic at the university for
46 many years in the School of Business and Economics and more
47 recently within the Law School. And, because of the

1 part-time nature at the Foster and Kinship Carers
2 Association, I was able to do that and take on other
3 part-time roles that presented themselves. And prior to
4 that I was Assistant Ombudsman across various jurisdictions
5 from 1999 through to 2006.
6
7 It's also mentioned that I took leave from FKAT and
8 was the Executive General Manager and more recently a Royal
9 Commission lead from 2018 to 2020 at Possability.
10
11 MS DARCEY: Thank you, and Possability is an agency; is
12 that correct?
13
14 DR BACKHOUSE: That is correct.
15
16 MS DARCEY: A foster carer agency. I should be specific.
17
18 DR BACKHOUSE: We've actually had children in special care
19 packages versus having foster carers there.
20
21 MS DARCEY: Thank you. If I could turn to you,
22 Dr Watchorn, could you tell the Commissioners, please, your
23 full name.
24
25 DR WATCHORN: I'm Julian Huxley Watchorn.
26
27 MS DARCEY: And your current occupation?
28
29 DR WATCHORN: I am a clinical psychologist.
30
31 MS DARCEY: Dr Watchorn, is it the case that you have
32 provided a statement also affirmed on 8 June 2022 for the
33 assistance of the commission?
34
35 DR WATCHORN: Yes, I did.
36
37 MS DARCEY: You have a copy of that statement in front of
38 you?
39
40 DR WATCHORN: I do.
41
42 MS DARCEY: Are you satisfied that the content of that
43 document is true and correct?
44
45 DR WATCHORN: Yes, I am.
46
47 MS DARCEY: Would you mind please just detailing for the

1 commissioners some of your qualifications and your
2 professional background?
3
4 DR WATCHORN: I undertook a bachelor of science in
5 psychology at UTAS and then a PhD in clinical psychology.
6 And since that time, I have practised as a private clinical
7 psychologist here in Hobart. I previously acquired - maybe
8 50 per cent of my work was forensic in nature, with the
9 Family Court or Child Protection matters. More recently,
10 I've stopped doing that. And since 2015, I've been working
11 with the foster carers association and for a brief period
12 when Kim was on leave I was acting CEO. More recently I am
13 involved in training and support services for foster and
14 kinship carers, including now informal kinship carers.
15
16 MS DARCEY: Thank you. Just before we hear about the
17 specifics of the positions that both of you have at FKAT,
18 Dr Backhouse, are you able to tell the Commission, please,
19 what the role of FKAT is and what it aims to do?
20
21 DR BACKHOUSE: Okay. I did mention it in the statement,
22 but just really quite briefly we're to provide support,
23 training and advocacy for all foster and kin carers and
24 informal kin within the State of Tasmania.
25
26 MS DARCEY: We have heard some evidence about this this
27 morning, but if you could just identify the types of foster
28 and kinship care that operate in Tasmania, and I think
29 you'll find that at paragraphs 19 to 24 of your statement,
30 that would be very useful.
31
32 DR BACKHOUSE: Would you like me to read those out?
33
34 MS DARCEY: If you could just perhaps note firstly the
35 types of family care, so what we'd term family care?
36
37 DR BACKHOUSE: Okay. We've got short-term foster care,
38 and that's provided for children and young people while
39 their family situation is being assessed. And the length
40 of stay can be from a few nights, and it might be a few
41 nights in emergency care, through to 12 months. And at the
42 end of the short-term care, the child or youth may
43 actually - they use the terminology now - "restored" to the
44 family, or they may have an option of being placed in
45 long-term care.
46
47 Long-term foster care is provided for children or

1 youth who need a stable, nurturing, supportive home until
2 the circumstances of their family may change or reach
3 adulthood.
4
5 Then we've got respite care. So that is provided for
6 children for short periods of time; it's actually at the
7 request of the child or youth, but in practical terms
8 sometimes foster carers may actually ask for that respite
9 care as well. Whenever possible, respite carers give a
10 commitment to be regular respite carers for the same
11 children for 12 or so months, so there's that consistency
12 in their life.
13
14 I'll just move on to kinship care. So kinship care is
15 a formal arrangement where foster care is provided by a
16 member of a child or youth's family. So it might be an
17 aunty, an uncle, a grandparent. In the child protection
18 system, kinship care must be explored before other
19 placements are considered. And then we go on to
20 specialised care, which is sibling groups, residential
21 care, therapeutic services. And I'm happy to discuss that
22 if you'd like me to.
23
24 MS DARCEY: Okay, look, we might just come back to that.
25 So, who does FKAT represent in terms of the carers? Do
26 you represent people who are department carers and agency
27 carers, or just one or the other? Do you represent
28 informal kinship carers, for example?
29
30 DR BACKHOUSE: That's a really good question. Our
31 membership base cuts across foster carers, kin carers and
32 informal kin more recently. By default the department has
33 an arrangement that departmental carers are members of the
34 association unless they opt out, and then we have
35 arrangements with some of the service providers that their
36 carers become members upon actually joining their service
37 provider unless, once again, they opt out of being a
38 member. So, I'm not aware of a situation where they've
39 opted out, so we have a large cohort of membership at FKAT.
40
41 MS DARCEY: Okay, thank you. In terms of your role, are
42 you able to briefly describe what your day-to-day
43 responsibilities are?
44
45 DR BACKHOUSE: Okay. So, I have a mixed role that can
46 range from briefing Ministers, sitting here today, spending
47 time out with carers with care concerns, which is a big

1 issue. Also, organising events and training right down to
2 writing newsletters, so it can go from a purely
3 administrative role to quite senior around systemic issues
4 and trying to encourage change within the sector.
5
6 MS DARCEY: Thank you. For how many hours are you
7 formally engaged or retained by the department?
8
9 DR BACKHOUSE: Through FKAT I'm formally retained 25 hours
10 a week.
11
12 MS DARCEY: In terms of being available to your membership
13 base?
14
15 DR BACKHOUSE: The reality is, there's access by members
16 to FKAT 24/7, and the reality is I've done more than
17 25 hours in this role when I'm actually - got the
18 permanency in that role. It's something that, if there's
19 an issue or a crisis it tends to go towards the afternoon,
20 early evening or on weekends, so FKAT likes to be available
21 to all carers in the state that require that support
22 advocacy at the time.
23
24 MS DARCEY: Are you the one who's holding the phone, to
25 put it colloquially?
26
27 DR BACKHOUSE: I do have the phone with me all the time,
28 apart from when I'm on leave and that's given by the Chair
29 of the board to answer those calls.
30
31 MS DARCEY: And so, FKAT does have a board?
32
33 DR BACKHOUSE: Yes, it does.
34
35 MS DARCEY: How do you interact or interface with the
36 board?
37
38 DR BACKHOUSE: So there's a diversity of board with
39 community members and foster carer membership, that's via
40 the constitution. Part of the board is, there's an
41 executive in the constitution that's made up of the
42 President, which is Chair, Treasury, Secretary, and Public
43 Officer, and so, there is regular meetings by the executive
44 that we talk about systemic issues or what's going on in
45 terms of the strategic direction of the organisation, care
46 concerns, themed areas. But in terms of the reporting, I
47 report to the Chair via the board and I have a weekly

1 meeting with the Chair of the board and have always done
2 that in that role to talk about what's most pressing.
3
4 MS DARCEY: Excellent. And, Dr Watchorn, would you please
5 explain the work that you do?
6
7 DR WATCHORN: With FKAT? So, it's been mainly in the area
8 of training and support. So, I developed a range of
9 training programs. The most significant one was a
10 trauma-informed care two half-day workshop that I conducted
11 with foster and kinship carers. I also provide support,
12 most often in more significant matters such as care
13 concerns, and I liaise with sort of senior staff in the
14 department around some individual matters like the care
15 concerns, but also some systemic issues as well.
16
17 MS DARCEY: Thank you. I understand that you're also the
18 Chair of the Family Based Care Providers' Group. Can you
19 please describe to me what that group is and how it ...
20
21 DR WATCHORN: It's been around for a number of years. I
22 joined approximately two and a half, three years ago as a
23 member representing FKAT, but in the last few years I've
24 taken on the Chair position with that. So, it composes of
25 representatives of the department, so senior staff from the
26 department, and also senior staff or CEOs of the service
27 providers in the non-government sector as well. On top of
28 that there's also a representative from CREATE, and there
29 has been a representative from the Tasmanian Aboriginal
30 Council.
31
32 MS DARCEY: We'll come back to some of the work of that
33 group a little later. I'd like to now, if I may, take you
34 both to the very beginning of the process where a child
35 enters into the out-of-home care system. We've heard
36 evidence earlier in the public hearings that a child will
37 be brought into the system under the provisions of the
38 Children, Young Persons and Their Family Act generally
39 because there's a concern that a child has been exposed to
40 serious harm through abuse or neglect or is at significant
41 risk of such harm within their family of origin. Would you
42 both agree with that as a general proposition?
43
44 DR WATCHORN: Yeah.
45
46 MS DARCEY: And in your view and from your experience do
47 you think that the department at that point in time would

1 know or be able to hold the knowledge of the full extent of
2 the harm or the trauma that a child might have been exposed
3 to at the time that the child enters the system? What sort
4 of visibility at that point will the department have about
5 that child's circumstances?
6
7 DR WATCHORN: If I could comment, obviously there's a
8 threshold and so the Advice & Referral Line is one where
9 they hope there's initial engagement that might not lead to
10 a situation where there's some more significant
11 intervention undertaken. So, one might hope in that
12 process that information is gathered over a period of time,
13 but my experience I guess from the foster carer's
14 perspective is that often they're given little or no
15 information in regard to the child or young person's
16 history, and particularly their trauma history when they
17 come into care.
18
19 MS DARCEY: Are there any standardised screening tools for
20 trauma symptomatology or even screening tools to
21 investigate the general health and wellbeing of the child
22 when they've --
23
24 DR WATCHORN: There's a range of tools but I don't think
25 any are being used in any regular way.
26
27 MS DARCEY: Do you think that there is a place for
28 comprehensive screening of a child at that very initial
29 point of intake?
30
31 DR WATCHORN: I think it's fundamental, particularly
32 looking at health-related issues. I gave an example of
33 having children who have been in care who are struggling at
34 school and then it's become identified six or 12 months
35 down the line that they have hearing or sight problems and
36 then maybe their behavioural challenges were as a result of
37 that.
38
39 If you consider that the threshold for them coming
40 into care is fairly significant, there's a high expectation
41 that most children or young people coming into care have
42 suffered trauma, and there needs to be an assessment of
43 that, and probably an expectation or a responsibility to
44 attempt to address that as early as possible.
45
46 MS DARCEY: Are there any barriers that you can see to
47 that sort of assessment being undertaken?

1
2 DR WATCHORN: Financial barriers probably, I think a major
3 one.
4
5 MS DARCEY: In terms of the timeframes that we might be
6 talking about with having to organise a child into a
7 placement, could that be a potential barrier or can these
8 assessments be done as soon as possible?
9
10 DR WATCHORN: No, they'll take time. I think if we look
11 at the availability of Allied Health professionals it's
12 quite a challenge I think in the state to actually have a
13 response undertaken in a timely manner.
14
15 I guess in defence of the department, there may be
16 many occasions where they have little or no information or
17 the family of origin is not willing to provide information
18 in regards to the child and their history, so it is a
19 challenging concept, but I often deal with children who
20 come to me privately who have obviously had a history of
21 trauma and, if there was more information it wouldn't be
22 the guesswork of trying to understand what has occurred.
23 Often you can make assumptions and they're probably fairly
24 accurate in regards to some of the triggers and the causes
25 of the trauma, but the more information one accelerates
26 that, but might also precipitate more immediate therapeutic
27 services for these children and young people.
28
29 MS DARCEY: Do you think that it might also assist carers
30 to understand whether that child is likely to be successful
31 as a placement with them?
32
33 DR WATCHORN: I'm not sure, could you --
34
35 MS DARCEY: Sorry, that was a really bad question. In
36 terms of the information that a carer has when they first
37 take a child into their home, how important is it that they
38 understand whether that child has a trauma history or
39 whether that child has some kind of other particular need?
40
41 DR WATCHORN: I think it's paramount. It may be that they
42 argue they don't have the information immediately
43 available, but if a child with trauma suddenly moves into a
44 strange environment it's going to be very challenging for
45 them and possibly triggering in many ways. An example
46 might be that they're sensitive to a raised voice so the
47 carer may not recognised that a slightly raised voice

1 triggers them into a fairly significant response. They may
2 have sensitivities to foods, there may be a whole range of
3 things that, if the carer was more informed, they could
4 approach it more sensitively and minimise the distress for
5 the child or young person when they come into care.
6 Because often we see for many of these children and young
7 people person there's two traumas, one is the trauma of the
8 family origin and then the trauma of being moved out of
9 that into a new family environment.
10
11 MS DARCEY: In situations where the department does have
12 information about a child, have you ever seen or heard of
13 the department withholding that information from the carer
14 on the basis of privacy, for example?
15
16 DR WATCHORN: There's been a frequent reporting from
17 carers that the department will say, "We can't provide that
18 information to you because it's confidential", which is a
19 bit of a sad state of affairs really. Obviously, there may
20 be information that is of necessity confidential, but I
21 think a lot of information would be highly relevant both to
22 the carer but to the child's wellbeing.
23
24 DR BACKHOUSE: And I have one example, if I may?
25
26 MS DARCEY: Certainly.
27
28 DR BACKHOUSE: A carer some years ago complained that it
29 wasn't mandatory in Tasmania to report that the child had
30 Hepatitis C and --.
31
32 PRESIDENT NEAVE: I'm sorry, I missed that?
33
34 DR BACKHOUSE: Hepatitis C.
35
36 PRESIDENT NEAVE: Sorry, I didn't hear that, yes, thank
37 you.
38
39 DR BACKHOUSE: And they understood that they didn't have
40 to report that and so that caused some great concerns to
41 the carer and the caring family that that information
42 wasn't disseminated at the time.
43
44 MS DARCEY: Look, correct me if I'm wrong, but would it be
45 fair to say that, right from the start of a placement,
46 there is potentially tension between the department and the
47 carer surrounding the provision of background information

1 about a child?
2
3 DR WATCHORN: Is there potential - a conflict, did you
4 say?
5
6 MS DARCEY: Is that a potential source of conflict between
7 the department and the carer?
8
9 DR WATCHORN: It can be, yep.
10
11 MS DARCEY: Are there continuing points of tension, do you
12 think, between carers and the department?
13
14 DR WATCHORN: It's frequently reported from carers that
15 there's often a conflictual relationship between carers and
16 Child Safety Officers.
17
18 MS DARCEY: I think at paragraph 48 of your statement,
19 Dr Watchorn, you talk about a conflictual culture and a
20 perception that perhaps, whilst lessening, has existed that
21 carers act in the role of the babysitter. Would you be
22 able to expand on that?
23
24 DR WATCHORN: It's a statement that we receive from carers
25 frequently and I think the term may not be used by Child
26 Safety Officers, but their actions and responses to
27 concerns give them that impression. So that if, for
28 example, a carer has concerns that they wish to raise about
29 the child or young person with the Child Safety Officer
30 they can often get a strong pushback and conversation that
31 would give them suggestions that their - that is not their
32 role: they're there to care for them, they're not there to
33 advocate for them. Whereas I see the opposite, I see them
34 as probably the most significant advocate for the child or
35 young person.
36
37 MS DARCEY: In paragraphs 108 to 112 of your statement you
38 also talk about having heard carers being referred to as
39 "too emotionally attached to the child". What are your
40 reflections on that?
41
42 DR WATCHORN: As I state in my report, I'd be very
43 concerned if they were not emotionally attached to the
44 child. So, we do get this regular - we on regular
45 occasions have feedback from carers where statements have
46 been made to that effect, "You're too personally involved
47 or you're too attached". And that also comes in when

1 children maybe leave care with a carer as well; there's
2 often a tendency to prevent an ongoing relationship between
3 the child or young person and their previous carer.
4
5 MS DARCEY: Would that kind of culture also flow through
6 in a situation where a carer is looking to become a legal
7 guardian of a child and, through that process of the
8 departmental approval of that carer into that much more
9 permanent role?
10
11 DR WATCHORN: Transfer of guardianship has been a very
12 difficult topic for a long period of time. Carers often
13 report it takes a long time for it to happen, or it doesn't
14 happen. More recently there's been some reforms in regards
15 to the criteria around transfer of guardianship but they're
16 not currently - they haven't become public information.
17 But my understanding is that it's a more complex nature
18 now, which I think is good in one way, it's more sensitive
19 to a whole range of factors. The concern I have is that
20 the complexity of it means that it may be very difficult
21 for foster carers or kinship carers to meet the
22 requirements of those items on the sort of checklist, if
23 you want to call it that, for transfer of guardianship.
24
25 MS DARCEY: Ms Claire Lovell, the Executive Director of
26 Children and Family Services, provided some evidence to the
27 Commission this morning; she was talking about, at one
28 stage, the fact that the department is working towards
29 every child in the out-of-home care sector having a Care
30 Team around them, and she was talking about the ideal look
31 of this team or composition of this team, and she noted
32 that ideally the team would comprise of the child, the
33 Child Safety Officer, another representative from Child
34 Safety Services, perhaps an educator with knowledge of the
35 child, other Allied Health professionals of relevance and
36 the carer of the child.
37
38 Do you have any views about the utility of a Care Team
39 that would be comprised in that way, and do you have
40 knowledge of the Care Teams that are actually in operation
41 at the moment?
42
43 DR WATCHORN: I think Care Teams are a concept that's been
44 around for decades with child safety: this isn't a new
45 concept. Care Teams decades ago had that composition,
46 maybe not the foster carer, but teachers, parents,
47 representatives from Child Safety. I guess the concern

1 that we have and this is reported from foster carers, is
2 that not every child has a Care Team or a care plan. But I
3 think that what they're making steps towards is recognising
4 foster and kinship carers as a more significant party in
5 that. Whereas in the past, particularly from the surveys
6 we've conducted, is that often if there is a Care Team
7 meeting, they're unaware of it; if there is a care plan,
8 they haven't been shown it. So, historically the reports
9 to us have been that they have not been included in any of
10 those sort of processes generally.
11
12 MS DARCEY: Thank you. Just going back to the issue about
13 the level of emotional attachment that a carer might or
14 should potentially have with a child and some of the
15 anecdotal evidence we have about Child and Safety Services
16 staff's view about that. Do you think that Child Safety
17 Officers are properly trained in trauma-informed approaches
18 to care?
19
20 DR WATCHORN: I don't think they are. I'm hopeful with
21 this model that we're developing and hoping to roll out
22 that not only foster carers but out-of-home care staff,
23 support staff, and Child Safety Officers complete the
24 training and have a better understanding of trauma, and
25 particularly recognising what might be behind behaviours,
26 because behaviours can be a sign of a range of different
27 difficulties and, without a good knowledge and sensitivity,
28 we may make assumptions that are incorrect and react to
29 behaviours in an insensitive way.
30
31 MS DARCEY: Just in terms of the role of the Child Safety
32 Officer and, Dr Backhouse, you might wish to contribute;
33 are there any other aspects of that role or characteristics
34 of that role which you think might make it difficult for a
35 Child Safety Officer to make a meaningful connection with
36 the child? Is it a time - do they have the time, do they
37 have the capacity?
38
39 DR BACKHOUSE: From the feedback that I've received over a
40 couple of years it can be very challenging for CSOs if
41 there's, like, high turnover, if there's vacancies, if
42 there's high absenteeism or low motivation within the
43 department, and then the expectation of a high workload on
44 top of that. I'm not saying that the KPIs within the
45 department set a high workload, but when you can appreciate
46 that those resources are not there, often those CSOs may be
47 stretched to take within their domain extra children in

1 case management, so that can just create complexities for
2 children and care plans and reviews that are being done.
3
4 MS DARCEY: Similar question but this time directed at
5 carers and particularly new carers, do you think that
6 generally they do have the skills to manage children who
7 have experienced significant trauma?
8
9 DR BACKHOUSE: As a general rule, no.
10
11 MS DARCEY: Are you able to detail the initial training
12 that a carer would undergo?
13
14 DR BACKHOUSE: Okay, so just from the outset I'd just like
15 to say that there is various service providers in Tasmania
16 and within those service provisions there's different
17 requirements with training. There would be some minimum
18 requirements that would be expected as a service provider
19 from carers, and one of those I would imagine would be
20 first aid training and medication training, and then other
21 service providers will have a suite of training.
22
23 So, I know with Life Without Barriers they had over 20
24 different short courses that carers could access that are
25 wide-ranging from trauma-informed right through to, how do
26 you identify sexualised behaviour
27
28 COMMISSIONER BENJAMIN: Were they compulsory courses or
29 were they voluntary courses?
30
31 DR BACKHOUSE: They're voluntary in most part. I would
32 imagine that first aid and medication might be mandatory in
33 terms of the service provisions, but I'm not aware of it
34 being mandated in any registration or accreditation
35 process.
36
37 COMMISSIONER BENJAMIN: Who would be required to pay that?
38
39 DR BACKHOUSE: That's an interesting question,
40 Commissioner. So, it's my understanding that the funding
41 that would go to the service provider would allow for
42 training to be provided to the cohort of carers that are
43 actually assigned to that service provider.
44
45 With respect to the department, the department has
46 internal training that they provide, and also FKAT is
47 funded to also provide training which we find over a period

1 of time that a lot of the departmental carers will access.
2
3 Once again, it's not mandatory training that's put up
4 by us, but we encourage carers throughout the state to come
5 along to trauma-informed training, first aid, training
6 around aggressive behaviours, around self-care.
7
8 PRESIDENT NEAVE: Are you able to tell us roughly what
9 proportion of your budget the amount provided for training
10 would be, by the department to you?
11
12 DR BACKHOUSE: I would say that around - I appreciate that
13 I've done an oath here, so I would not want to misrepresent
14 any facts --
15
16 PRESIDENT NEAVE: No, of course.
17
18 DR BACKHOUSE: -- but I would imagine it's around
19 40 per cent of the budget goes into training.
20
21 COMMISSIONER BROMFIELD: Dr Backhouse, if I'm
22 understanding correctly, it's conceivable then that the
23 Tasmanian Government is paying every agency to develop
24 trauma-informed training; that each care provider could be
25 developing the same set of training and the department
26 developing it too. Is there potential for duplication in
27 this model?
28
29 DR BACKHOUSE: In theory, yes, but in practice there's
30 discussion through the committee that Julian chairs around
31 what type of training is being available, and we've
32 certainly been encouraging a transparency of a calendar of
33 training for all carers in the state for some time that
34 recently has gained some motion through this committee that
35 we're on.
36
37 COMMISSIONER BROMFIELD: And so, for example, if I was a
38 carer with Key Assets, would I be entitled to access the
39 Life Without Barriers training?
40
41 DR BACKHOUSE: That's an interesting question and a very
42 sensitive one. So, my experience is that the service
43 providers are very keen to sign off on training that may be
44 provided by other service providers in the space.
45
46 DR WATCHORN: If I can comment on that. I guess the
47 foster care - Family Based Care Providers' Group is trying

1 to facilitate a more collaborative approach to a number of
2 issues, but this occurs in a competitive market and it's
3 unfortunate that it is. So, they compete for carers, for
4 recruitment, and there is some duplication, but we're
5 hoping that there is some - if we moved to some more
6 centralised training program such as TBRI that then is
7 mandatory, that is delivered by the department but is
8 mandatory for all foster and kinship carers, then we can
9 have some standards of expectation in regards to skills and
10 ability with carers and we're not having this slightly
11 competitive situation.
12
13 DR BACKHOUSE: And if I can add to that, there'd also be
14 consistency and a reduction in the duplication of any
15 training.
16
17 COMMISSIONER BROMFIELD: And presumably then some cost
18 efficiency which, of course, you then talk to.
19
20 DR BACKHOUSE: Then redirected to other training that I
21 think's important in the space such as self-care.
22
23 COMMISSIONER BENJAMIN: And then, if you start getting the
24 partnerships, which I think you were talking about earlier
25 on, you can then focus the training on the needs of the
26 child to meet their particular circumstances given the
27 trauma they're going through; is that a fair assessment?
28
29 DR BACKHOUSE: Yes. And I've certainly been advocating
30 that, if we have a registration system of carers in the
31 state whereby we also have accreditation, that if there's a
32 suite of training that's required for registration, there
33 might be the collaboration that one service provider may
34 provide trauma-informed training and another provider might
35 put on medication training, so that then also creates some
36 diversity, it also creates some inter-peer support with one
37 another and drives efficiency within the system.
38
39 COMMISSIONER BENJAMIN: In your statement you say that the
40 regulation is too light and that it needs better regulation
41 to protect children and also probably to optimise the
42 capacity of the carers to care for the children who they're
43 looking after.
44
45 DR BACKHOUSE: Most definitely. When I came into this
46 role several years ago I thought there would have been
47 pushback by the carers around the state with respect to

1 accreditation and registration but it was actually welcomed
2 by the majority of carers that I met face-to-face; that
3 they would prefer to have regulations and standards that
4 were mandatory; that they'd prefer to have an
5 identification card that could be used throughout the state
6 for various other things as well, such as maybe a reduction
7 in transport costs, access to the pool, so it would cut
8 across additional services for children.
9
10 MS DARCEY: Currently at the moment are there any criteria
11 that new carers need to meet and, if so, how is that
12 assessed? I'm thinking about the Shared Stories Model; is
13 that still in operation?
14
15 DR BACKHOUSE: It still is in operation, and I was talking
16 to one of the service providers last week and said that
17 that was their way of assessing new carers that come in to
18 be carers within this service provider. Julian, do you
19 have anything else to comment on that?
20
21 DR WATCHORN: I guess if we talk about mandatory training,
22 Shared Lives as mandatory training is part of an assessment
23 and then selection process for new foster and kinship
24 carers, so it provides some simple initial training and it
25 provides a period of assessment and observation of the
26 carers to assess suitability.
27
28 MS DARCEY: And how long is that period of observation of
29 the carers?
30
31 DR WATCHORN: A few weeks, I think, I'm not sure exactly
32 on the timing of it, and it can vary between service
33 providers.
34
35 MS DARCEY: This morning Ms Lovell talked about a
36 newly-created, although I believe it's a temporary
37 management position, that as I understand her evidence has
38 been tasked to audit data held by the department and other
39 organisations relating to basic approval requirements for
40 carers. Are you aware of what a basic approval requirement
41 might refer to or be?
42
43 DR WATCHORN: I'm not sure, I think it'll be consistent
44 with what we're talking about at Shared Lives. I'm not
45 sure what it is, though.
46
47 MS DARCEY: Are there any known criteria or a checklist of

1 criteria, or a --
2
3 DR WATCHORN: I think in the Shared Lives there is, I
4 can't remember exactly what's in there. So, it's really
5 just an initial training and assessment for suitability. I
6 think, hopefully, they will incorporate aspects of TBRI in
7 this initial training and also aspects of TBRI that relate
8 to carers' abilities but also their attachment style, so
9 that we can start to look at how their attachment style
10 marries with the child or young person and what might need
11 to be worked on to improve that situation, because
12 sometimes carers may be well intentioned but they may have
13 issues regarding that that may be problematic in their
14 ability to adequately and sensitively support a child or
15 young person.
16
17 COMMISSIONER BROMFIELD: Ms Darcey, I believe that
18 Ms Lovell's evidence pertained to some fairly basic things,
19 such as the carer being approved to have two children, or
20 other people who resided in the house at the time of
21 assessment: I think it was really very basic household
22 information that they were trying to ascertain that it
23 appeared wasn't on record or the records weren't being
24 maintained for; does that accord?
25
26 DR WATCHORN: I couldn't say if that was consistent
27 necessarily either between service providers. I think it
28 would be a great step forward. I think that the use of
29 data in assessing and even predicting situations of risk
30 would be a big step forward.
31
32 MS DARCEY: Well, I do apologise if I've misrepresented
33 what Ms Lovell's evidence was and I appreciate you,
34 Commissioner, pointing out your understanding.
35
36 Dr Watchorn, if we could perhaps just backtrack a
37 little bit and talk a little bit more about the Trust-Based
38 Relational Intervention Model that you've been talking
39 about, and that information is provided in your statement
40 at paragraphs 22 to 23 and then there's more information in
41 Annexure 2.
42
43 Can you give a brief description of what that model's
44 all about?
45
46 DR WATCHORN: It's a model that focuses on training carers
47 to provide therapeutic care to children and young people,

1 and I guess it contrasts with a more traditional model
2 where a child or young person, if there's any therapeutic
3 work they come to see someone like me for an hour a week,
4 and what they recognise is the work that needs to be done
5 is in the home on those other, you know, 18 hours a day
6 where there's more challenging behaviours and difficulties.
7
8 And so, it's a model I initially became aware of
9 because it was adopted in New Zealand. There was a
10 national adoption of this with some foster care agencies,
11 and so, maybe five years ago we were initially looking at
12 it and I had conversations with the department about that.
13 I don't know if I need to go over the principles of it, but
14 what's happened more recently is with the current statewide
15 manager of out-of-home care, Lionel Walters. Him and
16 myself have collaborated in developing initially a pilot
17 program and more recently the department has shifted to be
18 confident enough for us to start to - or for the department
19 to roll this out more significantly than just a pilot
20 program. The plan is that their training, train the
21 trainer training is occurring with departmental staff and
22 also staff from non-government agencies and then they'll
23 start to deliver that across the state to foster and
24 kinship carers.
25
26 MS DARCEY: Thank you. So, how are these projects
27 initiated? Is this something that you and Mr Walters have
28 come across or developed yourselves?
29
30 DR WATCHORN: Yes.
31
32 MS DARCEY: So is this a change that's been driven from
33 the bottom up, as it were, rather than --
34
35 DR WATCHORN: If I'm at the bottom?
36
37 MS DARCEY: Thank you.
38
39 DR WATCHORN: It's maybe not the bottom up, but it's -
40 there's certainly collaboration because I'm collaborating
41 with the department, but it's been initiated externally to
42 the department.
43
44 MS DARCEY: But as far as you're aware, there's no
45 overarching plan that the department has which would drive
46 the development of training of therapeutic models such as
47 this?

1
2 DR WATCHORN: Not specifically.
3
4 MS DARCEY: Thank you. Just thinking about the sort of
5 overarching or the systemic changes that might need to be
6 made to actually give these very important programs that
7 are being developed a chance to have maximum impact. If I
8 could just take you back to the issue of training: if you
9 don't have mandatory training, how effective is the work
10 that you have already done on these programs likely to be?
11
12 DR WATCHORN: It's certainly hindered by it. Mandatory
13 training gives us standards of expectation, but it also -
14 it's recognising that this model is a very suitable model
15 for the sector and that the outcomes of making this
16 mandatory is the wellbeing of children and young people at
17 a time when they're at most distress, I guess, when they
18 come into care. And my preference, and FKAT's preference,
19 would be that the Department of Education also consider it
20 as a mandatory training for teaching and support staff,
21 because we often have a circumstance where foster carers
22 report having difficulty communicating with the teacher of
23 a child or young person and, if there was a uniform
24 universal language and there was an understanding of the
25 TBRI principles, then I think we'd have a - one is a more
26 collaborative relationship between carers and teachers but
27 also a more sensitive approach to children and young people
28 in the classroom.
29
30 MS DARCEY: Is the idea that the training would be
31 extended to both carers and Child Safety Officers and
32 potentially to other agencies like the Department of
33 Education?
34
35 DR WATCHORN: Well, the hope is with education. Currently
36 the training is encompassing not just carers but also
37 out-of-home care support staff and representatives of
38 agencies, and I am expecting it to be also then Child
39 Safety Officers and other staff will be also participating
40 in it over time.
41
42 MS DARCEY: Thank you. The Commissioners have already
43 asked quite a number of questions, but in terms of the
44 concept of a carer's register, do you think, Dr Backhouse,
45 that that is something that should be implemented in
46 Tasmania?
47

1 DR BACKHOUSE: Yes, I think it's imperative for a whole -
2 it's multi-factorial the reasoning behind it, but if we're
3 looking at it from a perspective - I was talking with the
4 Chair of the FKAT board this morning and she was saying
5 that she's aware - I'm trying to de-identify this - she's
6 aware of a situation where a child was sexually abused by a
7 carer in the state. Because there's no registration
8 process, you're not able to deregister, that carer is
9 currently caring in New South Wales, and so, they're trying
10 to implement a mechanism where that particular carer can be
11 held to account.
12
13 So, if we're looking at worst-case scenario, the
14 registration system allows for deregistration, and so, we
15 won't have a situation where a carer may shop around to be
16 with a service provider if there was concerns raised.
17
18 PRESIDENT NEAVE: Can I ask about that, because I thought
19 carers had to have a vulnerable persons registration and
20 that does have some interstate component in it now.
21
22 DR BACKHOUSE: It's my understanding, unless they've got
23 something charged with the police, an employment-related
24 issue can go under the radar without a registration system.
25
26 PRESIDENT NEAVE: (Indistinct words) charge, there's no
27 conviction, just a suspicion - I don't mean "just a
28 suspicion", but a concern and then they go to another
29 state. So, really what used to happen in the past before
30 we had a better system for tracking the Caring For
31 Vulnerable People Registration and similar things in other
32 states.
33
34 DR BACKHOUSE: Yes.
35
36 PRESIDENT NEAVE: I see, thank you.
37
38 MS DARCEY: You've also mentioned, Dr Backhouse, that in
39 your view there should be at least a Code of Conduct for
40 carers in Tasmania. Why do you think that that is
41 important?
42
43 DR BACKHOUSE: I think it's important particularly - once
44 again for a lot of reasons. If you're a new carer that's
45 coming into this sector and you have children placed with
46 you, you may not necessarily know the responsibilities and
47 accountabilities with your role as a carer, and so, in a

1 perfect world you're providing quality care, there's not
2 any issues, you have an understanding without written down
3 of your roles and responsibilities: that's well and good.
4 But once you start to have a care concern and it's being
5 addressed by the service provider via the department or the
6 department directly with their carers it's too - it's too
7 fluffy if you don't actually have it set out in concrete
8 what your roles and responsibilities are.
9
10 Now, I've worked with the department in the past with
11 a roles and responsibilities sheet so that that can be
12 raised, brought to the attention of the carer in a care
13 concern, but I think that it should be mandatory and it
14 should be something that's widely published within the
15 department and all service providers so there's absolutely
16 no grey area whatsoever with that role and responsibility
17 that that carer has with respect to that child and youth.
18
19 MS DARCEY: And, Dr Watchorn, you speak in your statement
20 about the need for an overarching set of out-of-home care
21 standards. Now, as I understand it that's a different
22 concept to a Code of Conduct. Are you talking there about
23 National Standards?
24
25 DR WATCHORN: Well, I'm talking about state-based
26 standards that are consistent but the preference would be
27 to be consistent with National Guidelines that have been
28 around for a long period of time. And one aspect of that
29 that I've pushed frequently is this need for early
30 comprehensive assessment of children and young people when
31 they come into care in a timely manner. There has been
32 expectations within National Guidelines in regards to that,
33 but I'm not sure if the department are meeting those
34 National Guidelines.
35
36 MS DARCEY: Thank you. Just going to the care concerns
37 process within the department, I understand that FKAT would
38 be involved in that process in terms of representing the
39 carer sometimes.
40
41 DR BACKHOUSE: Yes, correct.
42
43 MS DARCEY: That would be correct? Now, I understand that
44 there are two main types of concerns: one called a quality
45 concern and one called a care concern, with the care
46 concern being the more serious concern and having a
47 definition that would be broad enough to include

1 allegations about severe abuse and neglect. Does that
2 accord with your understanding?
3
4 DR BACKHOUSE: Yes.
5
6 DR WATCHORN: Yes, it does.
7
8 MS DARCEY: Thank you. And that model of categorisation,
9 if you like, Dr Watchorn, do you see any difficulties with
10 that model or anywhere there can be improvement?
11
12 DR WATCHORN: There have been difficulties with that model
13 that have led to the department seeking to review and
14 create a more effective model in regards to dealing with
15 care concerns. So, up until now there's been a two-tier
16 system of care concerns. At the significant level is
17 what's termed a "care concern" and at a moderate level is
18 what's called a "quality of care concern". My involvement
19 in those cases with working with foster carers and kinship
20 carers has been that generally at the care concern level
21 there's a thorough, transparent investigation undertaken by
22 senior clinical staff within the department, that meetings
23 are minuted, timelines are given to carers and it's
24 conducted quite well.
25
26 What I have concerns though is the quality of care
27 concern level of a care concern nature that is often
28 informal, maybe undertaken by a team leader within case
29 management, and sometimes there's little transparency and
30 decisions are often made in a very immediate nature and
31 sometimes without a more formalised investigation gathering
32 information and interviewing the foster or kinship carer.
33
34 COMMISSIONER BENJAMIN: Can you give us an example of a
35 quality of care concern? A typical quality of care
36 concern?
37
38 DR WATCHORN: A carer has been observed at the swimming
39 pool responding aggressively to the child that's in their
40 care: that's an example of one that I've dealt with. So, a
41 member of the public has then reported that to Child
42 Protection and they classify that as a quality of care
43 concern.
44
45 Now, what's often unknown particularly to carers is,
46 what is on file? Has there been other information, any
47 other concerns raised? And sometimes carers report to FKAT

1 that suddenly an issue is raised of concern and it's
2 reported to them that it's of an historical nature but
3 they've been totally unaware of any issues prior to the
4 point at which they state that it's a quality of care
5 concern and there's an intervention
6
7 COMMISSIONER BENJAMIN: And I suppose something like that
8 can range from a stubbed toe to a verbal assault on a
9 child, could it?
10
11 DR WATCHORN: It can. The concern I have is that it is
12 very informal in nature and there is not a clear process.
13 I've attended meetings where decisions are being made
14 before the carer has even been interviewed, or there's been
15 reports that this issue of concern is historical and
16 therefore they see reason to remove the child from the
17 carer.
18
19 PRESIDENT NEAVE: And that's it's not a reviewable
20 decision, is it?
21
22 DR WATCHORN: No. And even in a care concern, if a carer
23 wants to appeal a care concern, they have to appeal to the
24 department.
25
26 PRESIDENT NEAVE: Yes.
27
28 DR WATCHORN: So it's a - you know, and it's very rare for
29 a carer to be willing, knowing that the difficulty that
30 might occur with that to make an appeal on a decision of
31 care concern.
32
33 DR BACKHOUSE: I have some feedback, if I may?
34
35 COMMISSIONER BENJAMIN: Sure.
36
37 DR BACKHOUSE: I'd like to see a parallel with
38 contemporary industrial relation law in Australia. So,
39 whereby, if an employee has allegations made against them
40 it's made to them in a timely manner where they're afforded
41 procedural fairness and natural justice. Very rarely do we
42 see situations within industrial relations law where staff
43 are brought in 12 months, 24 months, 36 months later with a
44 whole range of work practices that the employer's
45 displeased with.
46
47 So, often I receive feedback by carers where there may

1 have been one issue that has led to a care concern but
2 there's an iceberg of issues under that that's not been
3 raised with them.
4
5 COMMISSIONER BENJAMIN: I guess one of the interesting
6 things you'd want to think about is how that works in terms
7 of the responsibility for the child and the need to protect
8 the child in risk assessment, so I guess anything like that
9 would have to be fairly prompt, would it not?
10
11 DR BACKHOUSE: That's right, prompt.
12
13 COMMISSIONER BENJAMIN: And transparent and child-focused.
14
15 DR WATCHORN: And forensic hopefully in nature so that
16 some knowledge of interviewing children in an atmosphere
17 like that; understanding factors such as false allegations,
18 what percentage of allegations prove to be false. And the
19 priority has to be protecting the child or young person,
20 but sometimes it's a more complex matter that needs a more
21 sensitive approach to it.
22
23 DR BACKHOUSE: And sometimes I believe that the carers
24 that I've dealt with are happy for that frank and fearless
25 conversation with them about what they may not be doing
26 correctly, but sometimes they are - it's unknown to them
27 and that creates a level of anxiety and stress, there's
28 delays, that would have to impact on parenting that child
29 or youth.
30
31 COMMISSIONER BENJAMIN: And that gets back to your earlier
32 discussions, both of your earlier discussions about
33 training so people understand or carers understand the
34 environment in which they're working in terms of trauma,
35 clearly trauma-impacted children.
36
37 DR BACKHOUSE: And I've been involved with quite a few
38 care concerns where there's some pretty serious allegations
39 put forward to the carer. I've never heard a complaint by
40 the carer about what's been put up as an allegation, but
41 what I've always heard complaints about is the delays: it's
42 being unknown, they don't appreciate who they can actually
43 request further information from, who they can appeal the
44 whole process to.
45
46 COMMISSIONER BENJAMIN: And that gets back to
47 Dr Watchorn's comments, I guess, about a transparent and

1 forensic process.
2
3 DR WATCHORN: Can I make a statement in defence of the
4 department in this matter though? I had a lot of
5 involvement with the reforming of this model. I don't know
6 where that's at, but certainly these factors were being
7 taken into consideration in a newer model that was more
8 effective and transparent, and some of the information I
9 provided to the department was, the model that they have in
10 New Zealand in situations like this, which is a very
11 transparent model, everyone has a clear expectation of
12 roles and responsibilities, there's a clear timeline, and
13 they have it as a flow diagram. A carer can see, okay,
14 this is the process, this is what's going to happen sort of
15 thing. So, I know I provided that to the department as
16 there to consider in that process of the reform of this.
17
18 COMMISSIONER BROMFIELD: In relation to the quality of
19 care concerns, both of you spoke earlier about, I guess,
20 the possible tension that can arise when carers are acting
21 as an advocate for the child, and also the suggestion,
22 unhelpful suggestion that they may have been overly
23 emotionally involved - I believe that was your evidence,
24 Dr Watchorn. Are either of you aware of those kinds of
25 matters being raised in the context of a quality of care
26 concern, so the carer's advocacy for the child being raised
27 as a quality of care matter?
28
29 DR BACKHOUSE: Yes, I am aware of that.
30
31 DR WATCHORN: If I can give an example perhaps that has
32 occurred on a number of occasions. A child or young person
33 is having visits with their biological family and they come
34 back quite stressed and affected by it; the carer raises
35 concerns and the Child Safety Officer might say, you know,
36 "That's distressing for them, like, it's stressful, but
37 there's nothing wrong with that". The carer becomes more
38 concerned over time, raises the issue more significantly
39 with pushback, until such time as it becomes what might be
40 termed a quality of care concern where they feel the carer
41 is not willing to facilitate the child's relationship with
42 their biological family, and that can be a point of
43 significance where the department may remove the child from
44 the carer.
45
46 COMMISSIONER BROMFIELD: Thank you.
47

1 MS DARCEY: And in these more serious cases, do you think
2 that there is a need for a mechanism of either review or
3 perhaps a mechanism whereby an assessment can be made or an
4 Arbitrator introduced?
5
6 DR WATCHORN: I've pushed with the department, the
7 organisation, FKAT has, that we need sometimes an
8 independent tribunal to if not undertake the investigation,
9 is to assess the outcomes and to ensure that a fair,
10 transparent and effective process has been undertaken
11 leading to an appropriate decision that's in the best
12 interests of the child or young person.
13
14 PRESIDENT NEAVE: I understand that has been advocated in
15 some other reports, and I vaguely remember there was a
16 Glenfield report. I'm trying to dig it out of my memory.
17 Are you aware of any other states that have done that, had
18 some external review process?
19
20 DR WATCHORN: I'm not aware, I'm not really aware of
21 what's going on in other states to that degree.
22
23 MS DARCEY: I just had one last specific question for you.
24 I understand from both of your statements that the
25 department is no longer recruiting carers for the
26 department; is that correct?
27
28 DR BACKHOUSE: Yes.
29
30 DR WATCHORN: That's my understanding, yep.
31
32 MS DARCEY: That would indicate to me, and I'm not sure if
33 you have any visibility on this issue, but would it be the
34 case that a lot of departmental carers are getting older
35 in years, having been with the department for quite some
36 time?
37
38 DR BACKHOUSE: Most definitely. We did a survey
39 some years ago that highlighted that there was an ageing
40 demographic within the departmental carers and that there
41 should be some significant succession planning being put
42 into place now, as in, five years ago, to consider that
43 huge gap with the retirement of a lot of the aged carers
44 from this department.
45
46 MS DARCEY: Do you think that there are any implications
47 of this for the safety of children within the system? Or

1 is it really an issue about attrition rates?
2
3 DR WATCHORN: The Family-Based Carers Providers' Group has
4 raised the issue of the shortage of foster and kinship
5 carers and also the difficulty in recruitment. So, service
6 providers are struggling to recruit carers, so there is
7 definitely a shortage of carers. And the implications of
8 that are many. One initial one is in a perfect model, we
9 match a child or young person to the appropriate placement
10 and carer. We're nowhere near that option because we don't
11 have enough carers to be able to do that.
12
13 So, we struggle to recruit carers. I think there's
14 been, I guess, a lot of bad press around Child Protection,
15 and so it may be that people aren't necessarily motivated
16 to become foster or kinship carers, but I think at a time
17 where we're short of carers, I don't understand why the
18 department isn't recruiting, because it's a major issue
19 that the Family-Based Carer providers group recognises
20 across the sector.
21
22 MS DARCEY: Are there any other models of recruitment that
23 you're aware of from other jurisdictions that might work in
24 the Tasmanian context?
25
26 DR WATCHORN: We raised in the providers group the model
27 that is present in Victoria where there's like a central
28 portal for recruitment, and from that there's an equitable
29 distribution of carers to agencies and with some level of
30 matching of carers to placements. It hasn't been well
31 received, I think largely because we're still in a
32 competitive market, but I see that as very useful model,
33 particularly in a sector that's so under-resourced, that we
34 need to be looking at being more sensible in regards to not
35 duplicating and not wasting money, I guess, in a sector
36 that desperately needs more resources.
37
38 MS DARCEY: Thank you so much. I'd like to give both of
39 you the opportunity to add anything that you'd like to at
40 this point, and then I'll hand you to the Commissioners.
41
42 DR BACKHOUSE: I have a couple of points that I'd like to
43 make. The first point is, in terms of the tribunal that's
44 been mentioned, the tribunal could be used - have various
45 terms of references, but where I see a big gap is where
46 carers have come to me and said, "We've got an issue, the
47 children or youth are being previously reunified with a

1 biological family on a weekend and there may be an uncle
2 that's been involved with allegations of sexual abuse in
3 the past; they're concerned about the safety of the child
4 or the youth, and when a decision is made by the department
5 that it's of no concern with this particular matter and
6 they're really passionate about the fact that it is: they
7 don't really feel that there's an opportunity to take that
8 anywhere external other than to FKAT to try and advocate to
9 be involved with respect to review of that decision.
10 That's the first point that I wanted to make.
11
12 The second point that I'd like to make is, it came up
13 in a discussion that I had with the Chair of the board with
14 FKAT this morning and I think it's a really good one. It
15 would be really good, and it might exist but I'm not aware
16 of it: if there was an allocated person within the police
17 department that, when there's allegations of child sexual
18 abuse and carers are concerned, that they actually have a
19 specific contact point within the police department.
20
21 COMMISSIONER BROMFIELD: A specific contact for the carers
22 or a specific team who does the investigation? Can you
23 clarify?
24
25 DR BACKHOUSE: For the carer with respect to the child or
26 youth, because sometimes you could imagine the forensic
27 nature, it might take some time and they've got concerns or
28 issues and often they might want to make a phone call to
29 someone that's involved in the investigation and they might
30 have the name of a particular person within the police
31 department but they'd like someone that's been allocated
32 and had training, trauma-informed training, other training
33 involved and can appreciate the sensitivities at the time -
34 not suggesting that they don't, but that's been a request
35 that I make to the Commissioners.
36
37 COMMISSIONER BENJAMIN: Just so I understand that, is that
38 so the carer knows how to make life easier for the child as
39 the child may go through some process?
40
41 DR BACKHOUSE: Most definitely.
42
43 COMMISSIONER BENJAMIN: So it's so they know not to ask
44 leading questions or not to --
45
46 DR BACKHOUSE: Most definitely.
47

1 COMMISSIONER BENJAMIN: Is that the type of thing you're
2 talking about?
3
4 DR BACKHOUSE: Yes, and it might take some time, and the
5 13-year-old child's asking what's going on, where do they
6 go?
7
8 COMMISSIONER BENJAMIN: How can they get that information?
9
10 DR BACKHOUSE: Yes. So, there's various places they can
11 go to, but the feedback is, it would be very good if they
12 could have a direct line into the police department to have
13 that conversation.
14
15 COMMISSIONER BENJAMIN: Certainly not to protect the carer
16 against any allegations --
17
18 DR BACKHOUSE: No, definitely not, because the child would
19 be removed.
20
21 COMMISSIONER BENJAMIN: To help them manage the child or
22 assist the child through what may be a further trauma that
23 they're exposed to.
24
25 DR BACKHOUSE: Yes.
26
27 DR WATCHORN: And an expectation of what's appropriate,
28 what's appropriate to talk to them about, those sort of
29 things as well so that they don't hinder any forensic
30 investigation.
31
32 COMMISSIONER BENJAMIN: Yes.
33
34 DR WATCHORN: Can I - just a final comment from me?
35
36 MS DARCEY: Yes.
37
38 DR WATCHORN: The current reforms look very positive.
39 There's a number of reforms going on in different areas and
40 they're somewhat siloed unfortunately, but the sad state I
41 get to is an oscillation between optimism and groundhog
42 day, and I'm not sure which one I should be staying with.
43 I get a sense that we've been through - like, I've been in
44 this sector for 25 years and we've been through these peaks
45 and troughs of changes and improvements.
46
47 My concern is that there needs to be a cultural change

1 otherwise the adversarial nature of the relationships will
2 continue and any change will not be effective. There's
3 been an us and them mentality both sides of the fence, from
4 carers to child safety officers, and that's continued for a
5 long period of time and I think that there needs to be a
6 sensitivity around a more systemic cultural change to
7 enable the long-term success, I guess, of any of these
8 reforms that I think are positive that have been suggested.
9
10 MS DARCEY: Thank you very much.
11
12 PRESIDENT NEAVE: Thank you very much, Dr Backhouse and
13 Dr Watchorn, that was very helpful, thank you.
14
15 DR WATCHORN: Thank you.
16
17 COMMISSIONER BROMFIELD: And thank you for the work that
18 you do for the sector.
19
20 PRESIDENT NEAVE: Yes.
21
22 **AT 4.40PM THE COMMISSION WAS ADJOURNED TO**
23 **WEDNESDAY, 15 JUNE 2022 AT 9.30AM**
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