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

WITNESS STATEMENT OF ROBYN MAREE MILLER

I, Dr Robyn Maree Miller of [redacted] in the State of Victoria, Chief Executive Officer, do solemnly and sincerely declare that:

1. I am authorised by MacKillop Family Services to make this statement on its behalf.

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

Background and qualifications

3. I am currently the Chief Executive Officer of MacKillop Family Services (**MacKillop**).

4. I have 30 years' experience in community services, local government and child protection sectors, and have practised in both the public and private sectors as a therapist, clinical supervisor, consultant and lecturer.

5. I was a Consultant to the Royal Commission into Institutional Responses to Child Sexual Abuse (**National Royal Commission**). In this role, I was involved with the publication of the Consultation Paper on Institutional Responses to Child Sexual Abuse in Out-of-Home Care. Attached to this statement marked **RM-1** is a copy of this Consultation Paper.

6. From April 2006 until January 2015, I was employed by the Victorian Department of Human Services (as it was then) (**Department**) in a range of practice leadership positions:

   (a) I was Principal Practitioner in the Children, Youth and Families Division of the Department from April 2006 until December 2012;

   (b) I was Chief Practitioner, Child Protection and Youth Justice from 2010 until 2012; and

   (c) I was Chief Practitioner, Human Services and Director of the Office of Professional Practice from December 2012 until January 2015.

7. In my various roles with the Department, I was responsible for providing state-wide practice leadership, working in frontline practice with the most complex families, and policy and service development.

8. I was a Ministerial appointee to the Victorian Child Death Review Committee for a ten year period between 2003 and 2013. In this role, I reviewed circumstances and practices surrounding the deaths of 221 children known to child protection.

9. From 1992 until 2006, I worked in private practice part time as an individual, couple and family therapist. During this period, I also consulted and provided training to a broad range of organisations including the Department and Latrobe University where I lectured and supervised post graduate students in the Graduate Diploma of Family Therapy and Masters of Family Therapy courses. I also provided training to trainee psychiatrists on child abuse and trauma.

10. I have the following qualifications:

    (a) Bachelor of Social Science (Social Work) from the Royal Melbourne Institute of Technology;

    (b) Graduate Diploma in Family Therapy from Latrobe University;

    (c) Masters of Family Therapy from Latrobe University; and

    (d) Doctor of Philosophy from Latrobe University. My doctoral thesis examined cultural reform in Victorian Child Protection and Family Services and the Best Interests Case Practice Model.

11. Attached to this statement marked **RM-2** is a copy of my curriculum vitae.

MacKillop – overview

12. MacKillop was founded on 1 July 1997. We are passionate about working with communities so children can thrive, and our services are designed to support families so they can build on their strengths, and create an environment where children can develop their potential.

13. MacKillop's values are:

(a) Justice: We believe in the right of all people, regardless of belief or culture, to be treated justly and fairly;

(b) Hope: We commit to foster a hope that assists people to find meaning;

(c) Collaboration: We commit to working in a collaborative spirit through cooperation, coordination and partnership;

(d) Compassion: We seek to foster compassion, an attitude of the heart and a response to suffering; and

(e) Respect: We seek to act with respect with regard to each other, the earth and all creation.

14. We bring our values to life with the Sanctuary Model. Sanctuary is an evidence-supported, whole-of-organisation framework that is trauma-informed, focused on safety and guides how we respond as an agency. Sanctuary encourages us to rethink the way we manage conflict resolution and crisis intervention. It supports staff to form healthy communities and create a culture that prioritises safety and wellbeing at every level within an organisation.

15. The impacts of the Sanctuary Model are observable and measurable. Our results have shown improved communication and morale among staff, fewer incidents of client to staff violence and reduced staff turnover. A Staff Engagement Survey conducted independently in 2022 showed that MacKillop's staff engagement and morale is significantly above industry benchmarks. Our work, health and safety results have shown a 41% reduction in assault claims over the past few years and our Lost Time Injury Frequency Rate (LTIFR) is 2 points below the industry benchmark.[1]

16. Attached to this statement marked **RM-3** is a copy of the Sanctuary Model Factsheet.

17. MacKillop provides a range of services in the following streams: Child, Youth & Family; Disability; Education; and Heritage.

18. Residential care is one of the key services we provide to children and young people. MacKillop currently operates 65 residential homes, comprising of 42 in

[1] LTIFR Industry Benchmark for Residential Care Services is 18.5, Safe Work Australia.

Victoria (107 residents) and 20 in NSW (27 residents). We also have 36 residents in independent living placements in NSW.

Current role

19. I am currently employed as Chief Executive Officer. I commenced with MacKillop in July 2016.

20. My role is to lead and influence our 1,500 staff members and 800 foster carers and volunteers to achieve optimum outcomes for the children and families MacKillop serves. I am responsible for delivering on the strategic plan set by the Board and developing and implementing the operational plans annually. I am accountable for the work health and safety of employees and volunteers, and to the complex regulatory requirements for the children and young people.

The respective roles of statutory and not for profit providers

21. The statutory and non-government agencies are jointly responsible for the care and protection of young people in out of home care. Child Protection conduct the initial risk assessment and if there is a decision to take out a Protection Application to the court, the matter of removing the child from the family of origin and placing the child in care is ultimately decided by a Children's Court Magistrate. Whilst Child Protection may have made the emergency placement, the matter must be taken to court within 24 hours for the conditions and ongoing statutory orders to be determined.

22. Initially usually Child Protection hold case management, and different states have different cultures and practice in regards to the transfer of the case management responsibilities to the NGO. In the states of Victoria most of the case management responsibility sits with MacKillop (approximately 70% in foster care and just over 50% in residential care). In NSW all of the case management for foster care and therapeutic residential care sits with MacKillop. In WA however all of the case management sits with the department and Child Protection practitioners are the case managers.

23. Where a child is at risk in the community, mandatory reporters are required to report to child protection and any member of the community may report. Child Protection then conduct the investigation, and where there is physical or sexual

abuse police are notified and may also conduct an investigation that may result in criminal charges.

24. If the child is at risk whilst in care, it is the responsibility of the NGO to report to Child Protection and to the police. There may be a joined up approach to managing the risk and putting in place risk mitigation strategies. This may well involve the placement co-ordination unit within the department as well as the Child Protection case manager or the contracting team (who remain involved if the child is contracted for case management to the NGO). If a placement change is required the Children's Court is also notified.

25. An ongoing issue in the out of home care sector relates to the question of who is the "lead" person or expert with decision making power, in circumstances where there is a dispute about what a particular child in care might require. In my view, the answer cannot be an 'either/or' as it requires a 'both/and' approach and depends on collaboration and listening to who has the most knowledge about the case. Ideally there is a care team established where professional differences regarding the child's best interests are discussed respectfully. If there is a dispute, there should be a process of managing up the issues to more senior personnel who should be able to come to a resolution. Child Protection should not hold all the power as frequently there is very important information about the risks/strengths and protective factors within the family held by other agencies. Equally the agency should be respectful of the knowledge held by child protection.

26. In my role as Chief Practitioner at the Department, I was frequently called upon to conduct reviews of cases where there were disputes regarding complex risk issues and sexual abuse matters involving children and young people. My observations from these cases were that Frequently there was inadequate and fragmented information gathering, analysis and a lack of knowledge about sex offending dynamics and the proper interviewing of children. The common mistakes are when systems polarise around the 'overly optimistic' assessment or 'the rule of optimism' as some writers refer to it as, and the risk averse assessment, where there is failure to properly synthesise the facts and developmental norms.

27. There is a particular knowledge base regarding sexual assault and the patterns of disclosure and in particular that the norm is not to disclose in childhood, or to

retract the initial disclosure. The norm is that disclosure is delayed, partial and incomplete. Police frequently cannot pursue a criminal investigation because of the lack of evidence, however this does not mean that the child protection assessment is 'wrong' if there is an assessment, on the balance of probabilities, that abuse has occurred.

28. For these reasons, statutory and not for profit providers need to work together in sharing information, identifying emerging risks and discussing potential solutions to mitigate risks to children in care.

Assessing and managing risk of child sexual abuse

29. In 2012, during my time as the Principal Practitioner for the Department, I authored the Best Interests Case Practice Model. Attached to this statement marked:

    (a) **RM-4** is a copy of the Summary Guide of the Best Interests Case Practice Model;

    (a) **RM-5** is a copy of the Specialist Practice Resource for children with problem sexual behaviours and their families; and

    (b) **RM-6** is a copy of the Specialist Practice Resource for adolescents with sexually abusive behaviours and their families.

30. The Best Interests Case Practice Model provides a foundation for working with children, young people and families, and was designed to inform and support professional practice in family services, child protection and placement and support services.

31. The Best Interests Case Practice Model provides guidance for assessing risks posed to children, which involves addressing the following key questions:

    (b) Given all the information you have gathered, how do you make sense of it? Consider the vulnerability of the child and the severity of the harm:

        (i) What harm has happened to this child in the past?

        (ii) What is happening to this child now?

    (c) What is the likelihood of the child being harmed in the future if nothing changes? Hold in mind the strengths and protective factors for the child and family.

(d) What is the impact on this child's safety and development, of the harm that has occurred, or is likely to occur?

(e) Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?

(f) From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?

(g) If the circumstances were improved within the family, what would you notice was different – what would there be more of? What would there be less of? Who would notice?

32. The Specialist Practice Resources are a valuable tool for practitioners, designed as a useful guide to help practitioners deal with the particularly sensitive issues and situations, such as working with children and adolescents with harmful sexual behaviours.

33. With the introduction of the SAFER children framework in November 2021, these field tools have been superseded and are no longer used by child protection practitioners. However, they remain relevant and important.

34. In addition, there are a number of other resources to assist residential care staff in identifying and responding to risks to children. For example, the Implementation Guide for MacKillop's Power to Kids program (discussed further in paragraphs 46 to 54 below) sets out intervention models for harmful sexual behaviours, child sexual exploitation and dating violence. These models provide guidance on the responsibilities of residential carers, case managers, senior managers and the clinical team to ensure that identified risks are managed, escalated and responded to appropriately. Attached to this statement marked **RM-7** is a copy of the Power to Kids Implementation Guide.

Child sexual abuse in out of home care

35. There is overwhelming evidence that children and young people living in out of home care are at significant risk of experiencing harmful sexual behaviour, child sexual exploitation and dating violence. Within out of home care, residential care poses the greatest risk.

36. Research into children in our residential care has shown that 87% of all young people were known to have suffered significant family violence in their childhood, and 48% had documented experiences of some form of sexual abuse (usually interfamilial) prior to entering care.

37. Therefore, the out of home care system (including external agencies that interact with children in care) has to be designed on an assumption that children have experienced trauma, and might engage in behaviours that reflect those traumatic experiences. Those behaviours might include behaviours which:

    (a) act out their own experiences, if their experiences have included sexual abuse; and

    (b) seek the kinds of attachment, support or attention that they might not have had from their family of origin.

38. These are the cohorts of children that out of home care system must be designed to protect.

39. One of the ways that we can protect children is through encouraging a creation of, and maintaining a positive attachment with an adult. That is why in out of home care, MacKillop is always trying to establish a sense of trust and safety for the child.

40. That said, this means that children in out of home care are particularly vulnerable to perpetrators who are seeking to develop these connections. Children in out-of-home care may lack protective adults or family connections, may be placed with other children or young people who are being sexually exploited, disconnected or excluded from school or involved in peer or street subcultures accessed by exploitative individuals or networks. This may include criminal and sexual exploitation.

41. Their backgrounds may mean they have misconceptions regarding appropriate adult sexual behaviour and boundaries, are more sexually active than other children of their age, may misuse alcohol or drugs and be more likely to attach to adults who are supportive and show an interest in them.

42. Adults who sexually exploit children and young people frequently target those who they consider vulnerable and who they can abuse without being exposed.

Wanting to be loved and "feeling in love" can make young people vulnerable to exploitation. The children and young people are also disadvantaged as they have frequently missed out on appropriate sex education and modelling of healthy relationships.

43. This risk can be better managed through providing carers with strategies and an awareness of the circumstances in which abuse and sexual exploitation occurs can protect children in residential care. This includes carers developing an understanding of:

(a) the risk factors for harmful sexual behaviour in care, understanding grooming and the manipulation of predators;

(b) the increased vulnerability to abuse in care for some groups, including young children and children with a disability;

(c) the indicators that a child may be subject to sexual exploitation by others;

(d) the prevalence and impact of experiences of family violence, neglect and abuse both prior to and after entering out-of-home care; and

(e) their role and required actions and procedures.

44. Supporting children and young people to better understand potential risks to their safety and wellbeing may help them identify situations where they feel unsafe and increase the detection of abuse.

45. Better managing this risk also involves maintaining and strengthening the connections for young people with carers, their families, culture and community which can provide ongoing support in managing life challenges and crises well after they leave out-of-home care. Core to establishing safety and managing risk is the multi-systemic response where police, child protection and the NGO are working together to share information and to develop safety plans. Engagement with the parts of the young person's life that given them meaning is crucial.

Power to Kids

46. Power to Kids is a program that upskills carers, building their knowledge and confidence to have 'brave conversations' about sexual safety and providing

them with strategies to intervene early when they see indicators of abuse. The program is aimed at preventing, disrupting and responding to harmful sexual behaviour, child sexual exploitation and dating violence in residential care settings.

47. From 2017-2020 Power to Kids was designed, trialled and evaluated by MacKillop in partnership with the University of Melbourne and since 2021 is now being offered to residential care providers across Australia.

48. Power to Kids implements three prevention strategies:

(a) Whole-of-house respectful relationships and sexuality education – the components of this strategy include: training and coaching workers and carers in the whole-of-house approach, including on recognising and responding to harmful sexual behaviours, child sexual exploitation and dating violence; and educating children and young people about respectful relationships and sexual health and safety;

(b) Missing from home strategy – the components of this strategy include: establishing practice partnerships between each child or young person and their residential carers to counter grooming; and assertively engaging with children and young people using safety planning and social media to stay in touch especially when missing from home; and

(c) Sexual safety response – at the components of this strategy include: early identification, safety planning, advocacy and therapeutic treatment for harmful sexual behaviours and dating violence; proactively supporting exit strategies for child sexual exploitation; and joining up MacKillop workers with local child safety professionals and local frontline police.

49. Attached to this statement marked **RM-8** is a copy of the Power to Kids Factsheet.

50. Prior to the Power to Kids program, our residential care audits of over two hundred young people across three time points, revealed that approximately one third had exhibited some form of harmful sexual behaviour.

51. During 2018-2020, Power to Kids was piloted in four MacKillop residential care homes and its effectiveness was measured through evaluation interviews with and surveys to children, residential carers, clinical staff and management staff.

52. The evaluation report of the Power to Kids pilot program was released on 20 July 2020. Attached to this statement marked **RM-9** is a copy of the Power to Kids: Respecting Sexual Safety Evaluation Report dated 20 July 2020.

53. The qualitative data from the evaluation of Power to Kids indicated positive shifts on each outcome measure. The data indicated that:

    (a) children and young people were at decreased risk of harmful sexual behaviours, child sexual exploitation and dating violence;

    (b) children and young people were missing from homes less often;

    (c) safe relationships with carers were enhanced;

    (d) children and young people's knowledge, skills and attitudes about sexual health and safety improved;

    (e) workers were identifying harmful sexual behaviours, child sexual exploitation and dating violence and ensuring advocacy, exit and treatment;

    (f) workers were undertaking safety planning with children and young people;

    (g) workers had increased knowledge about harmful sexual behaviours, child sexual exploitation and dating violence; and

    (h) workers had increased self-efficacy responding to harmful sexual behaviours, child sexual exploitation and dating violence.

54. MacKillop is currently exploring the adaptation of the Power to Kids program in other contexts such as education and youth justice in Victoria.

IMPROVING CHILD SAFETY IN OUT OF HOME CARE SETTINGS

Child centred approach

55. It is important that residential care creates an environment that is as non-institutional as possible. It is about creating the kind of attitudes and

supports that one would hope children would have if they were able to live in their family of origin in a positive way.

56. This requires highly trained and supported team of professionals who are determined and passionate about making a difference to children's lives. This culture has to be driven from the leaders of the organisation. Organisations must avoid having hierarchical structures where things are delegated to the lowest trained staff member. At MacKillop I insist on co-ordinators, managers, directors, and therapists all being seen and present in our homes regularly.

57. It is critical that the system creates a sense of future for children and young people and builds up their sense of competence. To that end, the initiatives we have also introduced at MacKillop include:

(a) MacKillop Education which operates three specialist schools in Victoria suited to students whose learning needs and social and/or emotional behaviours cannot be adequately supported in a mainstream setting;

(b) Paw Pals Animal Assisted Education program which supports students who are currently disengaged or at risk of disengaging from education through animal assisted activities and individualised learning sessions;

(c) Healthy Eating Active Living Matters (**HEALing Matters**) program which aims to improve on not only the eating and physical activity habits, but also the wellbeing and life skills of young people living in residential care;

(d) We have also mandated every staff member to be trained in the Sanctuary Model and the evidence based model 'Therapeutic Crisis Intervention" known as TCI which was developed at Cornell University in the USA; and

(e) We have implemented an area based 'Community of Practice' where operational leadership and house managers and a 'champion' from each home, together with clinical staff meet each month for 3 hours to work through the practice actions that flow from the integration of the above models. We are using implementation science as the embedding of these models requires persistence and energy and must be supported top down bottom up in the organisation. The actions and 'homework' from each session are then enacted in each home as a

focus, and reported back on at the next month's Community of Practice.

58. We try to build teamwork and a common language and a culture that is genuine about 'walking the talk' about therapeutic care.

59. These programs can all be implemented in Tasmania, with support from the service providers. Sanctuary and Power to Kids can be facilitated by The MacKillop Institute.

60. The barriers to successful implementation in Tasmania may include lack of leadership and ensuring that there is back fill staff so that staff can be released. Some funding will be required but it is not excessive.

The necessary skills and attitudes required to work with children

61. The National Royal Commission found that the lack of supervision and structure, proper governance, poor complaint management and barriers to a child focussed culture, allowed abuse to flourish.

62. We need people who can show strong leadership in homes where carers are held accountable as well as supported. There is a need to have staff that can model trauma informed practice in situ so that the training is applied and practical.

63. Trauma informed means being focussed and curious about what has happened to the young person rather than being focussed on what is wrong with them. It is crucial to have an understanding of the impact of trauma on infant and child development in order to assist recovery and repair of relationships. It involves creating a consistent and predictable emotional connection with the young person that doesn't give up and seeks to repair and reflect with the young person when they have become dysregulated and stuck in a 'freeze, flight, fight response'.

64. Further, carers need to have the values and commitment to child rights and ethical practice, and a resilient, good humoured, warm character is essential. The children respond quickly to adults who are consistent, warm and genuinely interested and listening to young people. Empathy, understanding and skills that are responsive to trauma are essential.

Staffing structure

65. In my view, the work in out of home care requires carers with, at a minimum, a relevant Certificate IV and ongoing professional development and training. More senior roles (such as case managers and co-ordinators) should have degrees in related fields such as in social work or psychology, or a relevant graduate diploma plus experience.

66. This baseline knowledge is important because staff are being asked to do complicated work with children with complex trauma histories. It is a very intense type of work that requires layers of support from the organisation as well as continuous education.

67. It is important that residential care organisations build staff teams that contain therapeutic specialists. The therapeutic specialist provides therapeutic leadership and trauma informed interventions based on sound practice expertise and contemporary research that delivers positive outcomes for vulnerable children and families. Developing therapeutic strategies and plans for each individual child or young person, supporting and guiding staff, through reflective practice, in the implementation of these strategies. Plans to facilitate the development of new skills and perspectives to help them expand their strengths to facilitate healing and recovery. The Therapeutic Practitioner will also collaborate with the care team to plan and implement processes that strengthen the child or young person's relationship with their family and community.

68. I expand on some of the key features of McKillop's staffing structure, below.

Principal Practitioner

69. An important feature of MacKillop's structure is the Principal Practitioner positions. MacKillop has self-funded these positions, who are clinically trained and provide clinical leadership and supervision – one-on-one, in team meetings and in a group setting (called reflective practice, which occurs fortnightly with the team that helps to embed therapeutic understanding).

70. This has enabled us to support experienced practitioners who want to continue working on the frontline, rather than in a purely managerial role in an office. Further, it has led to positive outcomes for children as complex cases are able

to be dealt directly by experienced staff – and at the same time, experienced staff are able to supervise and educate less experienced frontline staff on a day to day basis.

Continuous education and development

71. In line with the Sanctuary Model, MacKillop has a strong focus on continuous education and development of our staff. We train every frontline and back office staff in trauma informed practice, therapeutic crisis intervention, HEALing Matters, and Reflective Practice. In my view, these skills that are being developed for residential care workers are transferrable to others who may need to have these conversations with children, including child protection workers and police officers.

Governance

72. MacKillop have also established the Residential Care Governance Group comprising the top 40 leaders in residential care. We share staff data and metrics to identify gaps and brainstorm strategies and solutions. This has strengthened our internal governance on risks to children.

73. The work of the Residential Care Governance Group greatly improved oversight over residential care and has led to a targeted and data driven focus on issues such as the recruitment and retention of residential care staff, staffing stability in residential care homes and a reduction of total numbers of staff rosters, monitoring learning and development strategy progress, compliance with supervision and safety and wellbeing checks and the quality of, and participation in, reflective practice. We have focussed on reducing aggression, engaging young people in education and training.

74. This could be implemented in Tasmania as it is a space that requires some preparation and the analysis of existing data on Work Health and Safety, Stability of staff in homes, Incident reports, Work Cover, etc. Triangulating and sharing this data has enabled higher level planning and commitment to continuous improvement.

Staff retention strategies

75. One of the challenges facing residential care is the high turnover of both staff and residents. It is difficult for children to create and maintain stable

relationships with their caregivers and peers, decreasing the likelihood that they will have someone they know and trust who they can turn to when they are unsafe.

76. In terms of staff turnover, MacKillop has introduced a range of initiatives which has improved our staff retention.

77. We have introduced Reflective Practice where clinical practitioners would meet with carers fortnightly to discuss and unpack complex issues they have encountered. Through Reflective Practice we have been able to recognise staff who were struggling with particular issues, which in turn enabled us to provide them with external support such as Eye Movement Desensitisation and Reprocessing (**EMDR**), Employment Assistance Program or expert secondary consultations for example in working with children and young people: with disability, using alcohol and other drugs (**AOD**), and exhibiting harmful sexual behaviours. EMDR is a psychotherapy treatment for staff designed to relieve distress, reformulate negative beliefs and reduce physiological arousal. EMDR has been much more effective than our Employee Assistance Program, particularly in circumstances where staff members have had significant exposure to self-harm.

78. While staff retention is important, organisations need to be conscious of the need to move on staff who are not suitable. We believe children and young people have a right to be safe, to learn, feel nurtured and connected to culture. A good residential care worker needs to be able to see beyond behaviour that can be confronting while practicing in a way that provides consistency, nurture and certainty for young people. Individuals who may adopt a punitive or combative approach to young people who have experienced high levels of trauma are not suited to the role.

79. At times there can be up to 20 staff on a roster for a single residential home, and it is often the case that good staff do not want to work in a team that does not function well. Well-functioning and cohesive teams can be established and maintained through regular high quality supervision, reflective practice, a clear leadership presence in the residential care that supports / reinforces expectations and maintain an environment that acknowledges successes and learns from mistakes and critical incidents.

Deep dive reviews and Outcomes 100 Project

80. At MacKillop, we conduct deep dive case reviews of all children in our care through the Outcomes 100 project.

81. The Outcomes 100 project commenced in July 2018, and involves proactively engaging in deep dive reviews into children and young people placed in our residential care. Central to each panel discussion is a deep listening to the people in care and the presentation of their worries and wishes. The collation of the data from this project has provided more intelligence on:

    (a) the nature of the children and young people in our care and their families;

    (b) the systemic barriers to good outcomes; and

    (c) 'what works'; and 'what needs to change' to improve the safety, stability and development of the young person.

82. Attached to this statement marked **RM-10** is a copy of the Outcomes 100: Residential Care Case Reviews Summary Report (**Outcomes 100 Report**).

83. In summary, the key findings and recommendations of the Outcomes 100 Report were that:

    (a) All residential homes should be funded as therapeutic with the capacity for staff to have individual time with young people to keep them safe and where both young people and staff have access to therapeutic response and support.

    (b) More case management transfer should occur to agencies to allow a more nimble and integrated response and enable a more coordinated focus on family engagement concurrently with risk mitigation strategies.

    (c) Family work is fundamental to address the mental health and anguish of young people and to support their connections and relationships with family. This will provide them with hope for the future.

    (d) A greater range of residential care options are required, specifically two-bed homes that are adequately funded. The four-bed model can contribute to the disruption and inadequate matching that occurs when there are highly disturbed young people requiring care.

(e) Some young people will spend their youth in residential care given their complex presentations and/or disability. They need a planned permanency approach and a stable ongoing home with ongoing funding that is not reliant on a contingency home being established as a reaction to a crisis, after cumulative harm has occurred.

(f) Missing from placement requires more urgent, systemic intervention and collaborative, planned work with police and other government agencies.

(g) Greater advocacy within schools and a stronger governance approach on the rights of children in care to an education is required.

84. The key barrier to implementing these recommendations is related to funding. Funding to support:

(i) including appropriately qualified therapeutic staff in the model of care

(ii) the training of staff teams

(iii) the provision of reflective practice and supervision time in the rostered hours in the residential care house

(iv) reducing the capacity of residential care houses

(v) an investment in building the skills and competency of existing workforce and retaining this workforce

85. Other factors that can act as barriers to implementing these recommendations include legislative, regulatory or practice impediments in interagency (police, schools child protections, mental health services, family support and family violence services) collaboration and information sharing.

86. Deep dive case review is not a requirement imposed by the government. Nevertheless, in my view, such reviews reflects good practice because it brings together a detailed understanding of the child's or young person's history and their progress with the internal and external senior decision makers – MacKillop, Child Protection and other relevant sectors – to address any blockages or drift and drive better practice.

87. In Victoria, the Department of Health and Human Services operates the Residential Care Performance Audit Program pursuant to which spot audits of residential houses are conducted. In my view, this program has improved the

quality of residential care in Victoria. A key weakness of a planned external audit cycle is that it can lend itself to an 'ebb and flow' of practice compliance with agreed standards – lots of work on compliance in the lead up to an audit then a lapse following. Unannounced audits support the ongoing provision of quality practice. Over time MacKillop has seen a broad and sustained improvement in results from these unannounced audits.

88. Work we have conducted internally reinforces that the children entering residential care are some of the most vulnerable and complex children in the community. Government has a duty to exercise effective oversight of the services that care for these children.

89. I would recommend the implementation of deep dive reviews in Tasmania. While the process requires an investment of time in aggregating data, preparing reports and attendance at the panel reviews, the benefits far outweigh the costs.

Children choosing to live outside of care

90. I am aware that Tasmania and New South Wales engage in a practice where older children, around the age of 15 or above, are given authority to choose their living arrangements outside of residential care. This practice is not followed in Victoria.

91. In my view, this may be a dangerous practice and I strongly agree with Victoria's position in this regard. Children with complex trauma history cannot give informed consent to such decisions, particularly in circumstances where they are choosing to live with an older, adult boyfriend or girlfriend who may be exploiting or abusing them. We should be providing a safe, nurturing placement for young people who are not only disadvantaged because of the lack of connection to family, but they have frequently missed out on education and their mental health is frequently very poor.

92. I have experienced a situation where a 16 year old girl left our residential care to live with her 40 year old adult 'boyfriend'. The dynamics of that relationship demonstrated to me that her boyfriend exercised powerful control over the young girl which had been established over a long period of time. Drugs were part of the manipulation and grooming where he tried to isolate her as part of

the exploitation as she had to perform 'favours' for his 'associates'. She was not able to make an informed consent as her trauma had impacted profoundly on her judgement and if we had not intervened her future trajectory would have been tragic.

93. Perpetrators are particularly clever in shifting the reality and turning children against the residential care service, by saying things like 'I'm the only person that truly understands you' or 'residential care workers are paid to give you attention, and I am not'. Due to the desire of children in care to seek the kinds of attachment, support or attention that they might not have had from their family of origin, they are extremely vulnerable to this grooming behaviour.

94. Allowing such outcomes to occur can often result in a realisation by the child, years later, that they were trapped in an abusive relationship under the watch of people who were meant to protect them. I am able to give many accounts of adults reflecting on this through my work as a therapist over the years, and the damage done in their childhood and adolescence.

95. Accordingly, the most protective thing that can be done for a child who may otherwise be vulnerable is to have a strong benign attachment with an adult. It is therefore critical that we are able to develop mentoring relationships with children in care. We provide mentoring programs in some areas to support young people in care which have been very positive.

Funding in residential care

96. To prevent child sexual abuse in residential care, governments need to fund them properly to have a therapeutic approach. That means ongoing development of staff professionally, proper supervision and deep dive case reviews of every young person. Adequate funding is crucial.

Relationship with Police

97. Keeping children safe requires an effective partnership with the police.

98. We have successfully worked with the Youth Taskforce at Victoria Police in setting up nimble information exchange to identify perpetrators and arranging surveillance of children young people in our care.

99. There is change on foot with policing, particularly in Victoria, NSW and some parts of Queensland. A part of the shift in the discourse, is changing from success equalling a criminal conviction to success equalling the safety of the young person and disrupting the sexual exploitation (which may or may not end up in a sex crimes process).

100. The police have reported to me that once they have started building rapport with the children and young people, that they are getting higher results in the criminal justice work. This focus on safety and disruptive policing and a multi-agency, 'joined up' response is a key aspect of keeping young people safe. The system needs to focus on the perpetrators much more in order for boundaries and safety to be gained.

101. An effective partnership with the police has been established in other states and I'm sure this can be or may well be the case in Tasmania. The engagement of the most senior leadership is crucial and regular meetings with senior child protection leaders and NGO leaders is crucial.

102. It is also crucial to have strong partnerships with education and mental health, and allied health services. Many young people in residential care or other forms of out of home care have disability and the access to proper NDIS planning and therapeutic and support services is vital for children and young people in care.

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

Declared at [redacted]
on 9 June 2022

[redacted]
.....
Robyn Maree Miller

Before me

[redacted]

[Full name of Justice, Commissioner for Declarations or Authorised Person]