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 17 June 2022 at 9.37am

(Day 14)

PRESIDENT NEAVE: Before we start, Ms Darcey, I have a restricted publication order to make. The next witness, Mr Robinson, has agreed to be identified but to protect the identity of other relevant people the Commission has decided to make two restricted publication orders. The Commission makes these orders because it is satisfied that the public interest in the reporting on the identities of certain people who may be discussed during this hearing is outweighed by relevant privacy considerations. I will now briefly explain how the orders will work.

The orders contemplate the use of pseudonyms in relation to a number of people. Any information in relation to the identity of those people must be kept confidential. This means that anyone who watches or reads the information given by our next witness must not share any information which may identify the people who will be referred to as: "Agnes, Beau, Cecil, Jethro, Linus, Wyatt and Tobias".

I make the order which will now be published. I encourage any journalist wishing to report on this hearing to discuss the scope of the order with the Commission's media liaison officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

Yes, Ms Darcey.

MS DARCEY: Yes, thank you. The first witness this morning is Brett Robinson and he will take an affirmation.

<BRETT JULIAN ROBINSON, affirmed: [9.39am]

<EXAMINATION BY MS DARCEY:

MS DARCEY: Q. Mr Robinson, will you please tell the Commission your full name?
A. Brett Julian Robinson.

Q. Thank you. Have you prepared a witness statement for the benefit of the Commission?
A. Yes, I have.

Q. You signed that statement on 2 June 2022?
A. Yes, I did.

Q. Since that time you've been provided with a copy of that statement with redactions?
A. Yes.

Q. Some things blacked out?
A. Yes, names changed and places and - yeah.

Q. That's great, thank you. Have you got a copy of that redacted statement in front of you?
A. Yes, I do, yep.

Q. Are you satisfied that the content of that document is true and correct?
A. Yes; yeah, completely.

Q. Thank you. Mr Robinson, you're joining us this morning from the Risdon Prison complex in Risdon Vale?
A. Yes, I am.

Q. And the reason for you coming this morning to give evidence to the Commission is, in part, to help the Commission understand some of the circumstances and in order that you might be able to help other people?
A. Yes; yes, it is.

Q. Are you hoping that the work of the Commission might lead to some change?
A. I'd just like to say that the next generation of kids, you know, who end up in the situation I did may not be treated the same and hopefully improve their situation a bit better than ours and mine.

Q. Thank you. Mr Robinson, if I could take you back, please, to a time when you were quite young, so primary school. You were living interstate with your mum and her partner at the time, and I gather that things weren't great?
A. Yeah.

Q. What decision was made about where you were going to live?
A. It was decided by my mother that I'd come back to Tasmania and go to live with my father at that time.

Q. When you got to Tasmania, was it just you and your dad living together?
A. It was just me and my father and his friend,

ex-partner at the time, yeah?

Q. Did you have a good relationship with your dad? Did you love him?
A. Yeah, definitely.

Q. And he loved you?
A. Yeah, most definitely. He's been my rock throughout my life, so, yeah.

Q. Did you ever feel unsafe when you were living with him?
A. No. No, not at all.

Q. And by the time that you were living with your dad had you been diagnosed with a mental health condition?
A. Yeah. When I was younger, 5 or 6 I think I was, I was diagnosed with [redacted], and a little bit older I was diagnosed with [redacted] as well, so yeah.

Q. Is it your understanding that your dad also suffered from a similar kind of --
A. Yeah, he also suffered [redacted].

Q. Okay, thank you. Was there a time where you and your dad had a bit of a rough patch?
A. Yeah, yeah. When I came back to Tasmania I wasn't medicated or anything like that, so my behaviour was up and down quite often, which caused a little - a few arguments and, you know, disagreements between us in the house, so yeah.

Q. And, by disagreements, how would you describe it? Was there sort of pushing and shoving and that kind of thing?
A. A couple of times there was pushing and shoving, but mainly it was just, you know, like, just upset and yelling, yeah.

Q. How long did that patch last before Child and Family Services became involved, would you say?
A. Probably over a two - two-week period maybe.

Q. At that time, were you going to school at least most of the time?
A. Yeah, at least most of the time I was up until probably the last week or maybe two weeks then, yeah.

Q. Prior to that, so in your primary school years, were you regularly attending school?
A. Yeah, I never missed a day through primary school.

Q. Thank you. Can you tell us, please, a little bit about the day that Child and Family Services came to see you and your dad. Do you remember those events clearly?
A. Yeah, quite clearly. Basically, we'd been arguing, and the police as well as Child Protection came to the house that night or that afternoon. Basically, as soon as they arrived the police and a Child Protection Worker walked me down to the car which was parked out front of our unit complex and sort of sat me in the car, and they basically told me that they'd be back in a couple of minutes to talk to me, and then they went and spoke to my father - well, one police officer sort of stood outside the car. Then probably five, maybe 10 minutes later I could see my dad was quite stressed, like, he was getting upset, but he came down and basically just said to me, he goes, "Look, you have to go with these for a little bit", (indistinct words). So, basically just told me to stay strong and it'd be over in a couple of days, and that was basically the brinks to it, yeah.

Q. So, what was your understanding of what was happening?
A. To be honest, I didn't really understand, I just knew that that - like, once I was in the car they told me that, you know, my dad needed a break and probably I needed a break as well, and that I'd be going to a house, yeah.

COMMISSIONER BROMFIELD: Q. Mr Robinson, could you tell me how old you were then?
A. I would have been 12 or 13, I think.

Q. So maybe last year of primary school or first year of high school?
A. First year of high school.

COMMISSIONER BROMFIELD: Thank you.

Q. So once you were in the car, where did you head off to?
A. First we went into town, went to the Child Family Services office and then drove out to [redacted]. Sorry.

Q. That's okay. And so, you went to a [redacted], I think you describe it?

A. Yeah.

Q. Can you tell us a little bit about what that was?
A. Basically, I arrived there and my understanding at the time, I didn't really understand it at the time, but I now know that, like, [redacted] is just so - so there are a number of kids there. There was one other kid there when I arrived, and basically they had two carers that were working on rostered shifts, they'd both - they'd work 12-hour shifts, so they'd start at 6 and change over at 6 at night, yeah.

Q. And the other kids there, did you know much about them or did you learn?
A. Before I got there I didn't know them at all but, I mean, after I got there, like, there was one who was, like, he'd only been just out of Ashley and there was no kid there that was, like, continuously on - he was using drugs as well as chroming and, yeah; like, it was just a mess.

Q. So that was, you observed that or knew what was going on in that facility or that house?
A. Yeah, it wasn't really hidden, it was pretty open.

Q. So when you got there, as I understand it, your understanding was that you were going to just be there for the weekend?
A. I was told that I would be there for a week and then that'd be it.

Q. So, after that time had passed were you told anything else about what might be happening for you next?
A. I was told that I'd be there for a week and it wouldn't be any longer than that, and basically throughout that week of - we were taken to Child Protection and told that a six-month order was being put in place, and that yeah - basically they'd start to organise weekly visits and, yeah, that was about it.

Q. And so, what was your reaction to that? What was your first instinct?
A. I was definitely confused, I was quite emotional, yeah; it was quite a bad time for myself and both my father as well, dad was quite upset and wanted me home, so, yeah.

Q. And what was your overriding instinct? What did you end up doing?

A. After that I was just continuously running back home. Basically, I think it was the next day even after getting back to the [redacted] that I first ran off and I was basically just running back to dad's.

Q. And when you say you were running back, as a 12 or 13-year-old, what did it actually take for you to get back to your dad's; how did you actually manage to do that?
A. Well, sometimes I'd jog, sometimes I'd walk and I'd be - yeah, it's probably 5, 6 kilometres back to dad's maybe.

PRESIDENT NEAVE: Q. [redacted]
[redacted]?
A. [redacted]
[redacted].

MS DARCEY: Q. And the first time that you actually did make it back to your dad's and I understand you did get to speak to your dad on that time, what did he say, what was the conversation between you about that?
A. He was quite upset, basically he just told me that, you know, "If you're ever gonna get back home then you need to do what they say", basically, yeah, told me to keep me head up and stay strong.

Q. And at this time, were you going to school at all?
A. Since being in - no.

Q. Since you left your dad's, you didn't go back to school?
A. No.

Q. Did you ever go back to school?
A. For a little bit there I went to a place called [redacted]; it was, like, just a - it wasn't like a - it was a made up school environment, I guess.

Q. Okay. I understand that you went to a number of different types of places and that you were in and out of different types of care, and at one point did you get moved to a place where there was a carer who we're going to call "Wyatt"?
A. Yeah; yes, I did, yeah.

Q. What was your relationship with Wyatt like?

A. Very volatile from the start. I didn't like him, he didn't like me. He basically - he didn't like me from the start because I wasn't going to school. The other kids that were there were going out for the day or going to school, and I guess that was sort of his time and, yeah, so him having me there, he didn't like the fact that, you know, I wasn't at school so he didn't like me.

Q. So, how did he resolve that problem, of you hanging around?
A. He basically - he started to set me up through the day and then basically he'd organise that he'd take me up to the [redacted], sit there with a fishing rod and sit there from probably about 10 o'clock in the morning till 3, 4 in the afternoon. Sometimes he'd come back and check on me, yeah, that was about it.

Q. I don't imagine you caught many fish at the [redacted]?
A. No, certainly didn't.

Q. While you were in that placement, did you sometimes go to somewhere else on the weekends, and we don't need to say where that is?
A. Yeah. Yes, I did, yeah.

Q. And at that place, how many people were there at that place, and how would you describe them?
A. There was two carers and another boy that lived there. Both the lady that lived there and her Partner, they were quite nice people, but yeah, the boy wasn't.

Q. So, the boy we're calling for today "Linus", okay?
A. Yep.

Q. When you were at that place where did you sleep, where did you stay?
A. So, basically, it was - there was a house [redacted].

Q. And, without going into any detail and only if you feel comfortable, can you tell me, please, what transpired during that time?

A. He was - he would come up into me room and basically make me touch him and force me to lay there while he touched me and, yeah. Yeah, yeah.

Q. Did you tell anyone about what had happened?
A. To start he told me, he said, mate, to make sure to shut me mouth and not to tell anyone. And, for the first couple of weeks I didn't, and then I ended up telling the carer back - sorry, I can't think of --

Q. Linus? Sorry, Wyatt, the carer Wyatt?
A. Yeah, Wyatt, sorry, I told him, and he basically just told me to shut me mouth pretty much, thought that I was - yeah, he thought that I was lying pretty much, so I pretty much did. But then a couple weeks later I had a visit with my mother and father and I told them and they contacted police and, yeah.

Q. I understand that you did have an interview with the police, but how did that go? What happened there?
A. The police organised me to go down to the police station to do an interview. We sat out the back, my mother and father were both there as well; they sort of sat at a bit of a distance. And I spoke to the police with things leading up to what had happened, but when it come time to actually give details, I just - I wasn't able to - I couldn't talk, like, I just - I kept getting real emotional and I guess agitated at myself, so I cancelled the - well, I just didn't want to do the interview. And the police said to me that, if there was a time when I felt more comfortable to talk about it, to make contact with them and, yeah.

Q. And, did you ever go back?
A. No.

Q. And so, after that time I understand that you kept moving about, you were moved even further away from your dad's; you were still trying to get home to him?
A. Yeah, yeah. I was basically moved from one end of the state to the other on a couple of occasions. But pretty much wherever I went I was always trying to get back. Like, at one point they moved me all the way down the other end of the state, and I basically tried riding back on me pushbike.

Q. And how did that work out?

A. That didn't work out at all, they ended up driving up on me and, yeah.

Q. So when you say driving up, who was driving up behind you; the police?
A. No, the carer from the house where I was, he - yeah, he tracked me down, I was on the highway riding up and come up and put the bike on the back and drove me back to the house.

Q. Is it fair to say that at that stage you were dealing with what had happened with Linus, you were still desperate to get home to your dad?
A. That's where I wanted to be, you know, I mean, that's where - that's where I felt safe, you know what I mean, that's where I needed to be.

Q. And so, after moving around a few more times at different placements and things, is it the case that you then started to live on the street?
A. Yeah. It got to the point where I'd rather - I'd try and run back to dad's and I'd get there and the police would be waiting there to take me back, so it just got to the point where it was a waste of time even trying to go back. Yeah, at that time anywhere was better than the care houses, so occasionally I would just sleep on the street or occasionally I'd - occasionally I'd break into a car and just sleep in the back of it, yeah.

Q. Did you have any access to any money?
A. No. No, I was - basically everything I had, I was - I was stealing. I wasn't able to get Centrelink benefits at the time due to me age and, yeah.

Q. So, even, like, your clothes, did you have any gear at all?
A. I had heaps of clothes when I first went into care, but every single time I got - I'd get moved to a new house, my clothes and belongings just get smaller and smaller, like, I'd lose things and forget to pick up certain things, and it got down to the point where I had, like, a backpack with a couple jumpers and t-shirts, that was about it.

Q. And then, as I understand it, you and another person - and we don't need to talk about who that person was - but you and another person decided that you wanted to get out of Tasmania and go to the mainland?

A. Yeah.

Q. How did you, just in a general way, how did you decide that you were going to make that happen?
A. Basically, I came to the decision that I - I was sick of getting taken back to the care houses and moved around, and so, I decided that I needed money and ended up committing a robbery to get that money and I was going to use that money to try and buy a plane ticket and go.

Q. How did that work out?
A. Not good. Basically, the robbery happened, I was arrested not long after and that was when I first went to Ashley Boys Home.

Q. You've told us that you were on a six-month order.
A. Yep.

Q. Had that order expired or were you still on that six-month order at this time?
A. No, I was still on that six-month order.

Q. So, all of this, everything you've told us this morning, happened within a six-month period?
A. Yep.

Q. Can you tell me, please, what happened when you first got to Ashley; what was the very first thing that happened?
A. I was taken out to Ashley in a [redacted], and - sorry if I use the name - I was taken there, basically they take me through in the Admissions Unit, which is like where they sign you into the place pretty much. I was put into - they were just like empty cells, fish tank or whatever you want to call it. I was left there for a couple of minutes and then their worker came in and basically started doing a strip-search. I got down to basically my boxer shorts. I'd already been searched at the police station, like, and I didn't have to take my boxer shorts off so I didn't think that I would. So basically I got down to me boxers and then I went to pick me clothes up and he said, "No, you need to take your shorts off". I basically pretended that I didn't hear him and went to continue to try and get me clothes and he slammed me to the ground, pretty much ripped me shorts off me, and then he said to me, he said, "You're not listening". Then he ran his finger basically through, between my butt cheeks and inserted a finger in and said,

"Welcome to Ashley, boy, you do as you're told". And then, sort of stepped back and said get dressed pretty much, and then he left me in that cell for probably another 10, 15 minutes while I got dressed and then him and another worker basically came back in and took me in through to my cell.

PRESIDENT NEAVE: Q. How old were you by that time, Mr Robinson?
A. Sorry, what was that?

Q. How old were you by this time? Are you 14 or are you still 13?
A. No, I would have been just 14.

PRESIDENT NEAVE: Just 14. Thank you.

MS DARCEY: Q. Mr Robinson, how would you describe your treatment while you were at Ashley in terms of the physicality between Ashley staff and people like yourself?
A. To be honest, it was - it was horrible. Basically it was, you were made to feel like an adult, and you were just treated like shit; you were belittled. I lost track of the amount of times that I was told that I was a drug baby, you know, I wasn't wanted and, you know, this was all I was ever gonna be and, you know, stuff like that, it was continuous; you know, it was just how they spoke to you. I mean, don't get me wrong, there was a couple of nice ones that, you know, worked there and they wouldn't treat you like that and, you know, when they was working they'd basically keep other officers in line, I guess, but it was - yeah, there was only one or two of them, so it was, yeah.

Q. In your statement you make a reference to being hogtied. For the benefit of the Commission, can you explain exactly what's involved in that?
A. So basically there was one time I didn't go back to me room quick enough so they basically came in, into the common room and grabbed me and slammed me to the ground, and then they'd basically handcuff my hands behind my back and then handcuff my ankles together and then handcuff my ankles to my hands so that I was practically hogtied, and then --

Q. Sorry, can you please explain, because it's something that I certainly hadn't appreciated, what are these

handcuffs actually like?
A. So, they're basically, you've got the actual handcuff and then through the middle it's just, it's like solid black plastic so that there's - they're called control cuffs and basically, so when they're put on they can grab the middle of the cuff and basically turn it even a little bit and if it feels like it's going to snap your wrists off.

PRESIDENT NEAVE: Q. Can I ask, did you get any treatment for your mental health condition when you were in Ashley?
A. Later on I started seeing a [redacted] there named [redacted], but yeah, I think we spoke maybe two or three times.

Q. And did you get medication or talking --
A. No, no there was no medication or anything like that, it was just like counselling, I guess.

PRESIDENT NEAVE: Okay, thank you.

MS DARCEY: Q. Mr Robinson, when you were at Ashley were you ever isolated, kept in your room?
A. Yeah, to where - the longest, the longest that I was ever actually isolated in my room for was about six weeks. Yeah, it happened quite regularly. Basically, like, it was no certain unit, basically it was called ISP, which stood for Individual Support Program, and basically they'd - every Wednesday they ran a meeting to discuss your overall weekly behaviour, and so basically they'd come round and that and if they decided that your behaviour wasn't up to standard they'd put you on ISP for a week which meant that, yeah, I'd just be in my room and seven days later they'd come back around and if I'd been behaving they'd let me out. But I mean, if you'd go to officers that didn't like you, they'd just basically write a book and stuff and say that you'd abused them, and then write to a friend, and that was enough to keep you in ISP for another week.

COMMISSIONER BROMFIELD: Q. And in your room, so you're in your room with no-one else, what did you have in your room to keep you occupied?
A. Well, when I was on ISP they'd basically come in at 8 o'clock in the morning, they'd take your bedding, take your bedding out of your cell and basically anything that was considered privileged would be taken out of your cell;

you'd have a couple of books, a puzzle, yeah, that was it. You had a TV in your cell but it was turned on and off in their office, so yeah, that was never turned on.

MS DARCEY: Q. Mr Robinson, after you had come out of Ashley for the first time, can you just tell us how things went for you after Ashley in terms of your life?
A. Basically, I came out and by that point they had already put in place another Child Protection Order, so I was sent back into one of the group homes that I'd been in before; basically, I just went downhill, so using drugs, drinking, running away, but pretty much as soon as I'd get out they'd want to put me in a group home and I'd pretty much just run from the second I got out the gate and I'd run until they caught me and, yeah, I'd be on me way back.

Q. Thank you very much for sharing everything that you have with the Commission today. Is there anything at all that you would like to say?
A. If anything does come out of it, whether it's this centre or the next centre, just flood the place full of cameras, you know what I mean, make sure that these kids haven't got an angle where they don't feel safe, because it's - it's wrong, it's destroy - it's destroyed my life and it's destroyed many other lives that I know, so yeah. Other than that, no, thank you for your time.

MS DARCEY: Thank you.

PRESIDENT NEAVE: Thank you very much indeed, Mr Robinson, it took great courage to talk to us and we do hope that we'll be able to make recommendations that stop these awful things happening again, and we do wish you all the best for the future?
A. Thank you.

Q. You're a young man, you're obviously an intelligent, thoughtful man, and I'm sure that - I hope very much that in the future you'll be able to have a good and happy life.
A. Thank you. Thank you very much for your time.

PRESIDENT NEAVE: Thank you.

MS DARCEY: Thank you. And, we'll take a break.

PRESIDENT NEAVE: Yes.

SHORT ADJOURNMENT

MS ELLYARD: Thank you, Commissioners, the next witness is the Commissioner for Children, Ms Leanne McLean. She's given evidence before but I'd ask that she have the oath or affirmation administered again.

<LEANNE DELANY MCLEAN, affirmed: [10.21am]

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: Q. Good morning, Ms McLean. Can I ask you to tell the Commission again your full name?
A. Leanne Delany McLean.

Q. And you're the current Commissioner For Children and Young People in Tasmania?
A. Correct.

Q. You gave evidence before in the first week of the hearings in the overall context of the structures that exist in Tasmania, but you're here today to speak more particularly about the role that you perform in relation to the out-of-home care system?
A. That is correct.

Q. And so, you've previously made a statement which has previously and been adopted by you as correct?
A. Yes, that's right.

Q. And we're going to talk to some of the details of that insofar as it relates to out-of-home care. Firstly, the point that you make in your statement, and this is beginning in particular at paragraphs 40 and following, is that although you do have a role in the oversight of out-of-home care, it's not a role that one would find if we looked to your guiding legislation?
A. That's right, no, you wouldn't. The Commissioners Act which was reviewed in 2016 wasn't initially envisaged to include that function, and in fact there is no direct function that relates to the monitoring of out-of-home care or oversight of out-of-home care as you would see in other jurisdictions.

There are two areas or two functions of the Act that I monitor through, and they are 8(1)(c) and (d) and they are really about influencing policy and legislation. So,

there's nothing specific in the Act.

Q. As I understand it, your role in engaging in a degree of systemic monitoring arises out of the work of your predecessor?
A. That's right. In 2017, after some particular allegations in relation to an organisation that was raised in evidence yesterday, Safe Pathways, the Commissioner at the time I believe was asked to undertake a review into the out-of-home care system.

In 2017 he released a report which included a range of recommendations around oversight, including embedding a visitor's program, including embedding individual advocacy for children, including introducing the concept of reviewable decisions through a tribunal, and the government accepted those recommendations at that time, and that led to a range of changes, including the announcement that the government would fund the Commissioner for Children and Young People to implement systemic monitoring of out-of-home care.

Q. So you received money to do it and you've got a general power under your Act that permits you to do it; is that right?
A. Yes, two general functions under the Act that permit me to do it, and I can use my powers to execute those functions in relation to out-of-home care, but to be honest, you really need to, you know, cross your eyes and hold your mouth right to really understand exactly legislatively how you can do it, and there are, I believe, ambiguities which are unhelpful.

Q. And, by ambiguities, you mean things that make it unclear, for example, how far you can go in the monitoring that you under take?
A. That's right, how far I can go, whether or not, for example, I could investigate a particular organisation who may be a provider of care. My understanding is that I can investigate systems, policies, practices pertaining to the system, and that I could approach the investigation of an organisation based on that lens, but actually launching an investigation into an organisation itself, my understanding is that that would not fit within the current Act.

Q. And it sounds like you're also not really funded to do it either; the funding that you've got pays for the current

systemic monitoring, there wouldn't be any fat in that budget for anything more?
A. No, the funding we received was to fund the equivalent of two full-time Band 6 policy officers. In addition to that, the monitoring program takes up a significant amount of my time and a significant amount of the manager and director's time.

The conceptual work underpinning - actually, I'll take a step back. The monitoring program - the first question you would ask yourself if you were given the task of a monitoring program by a government is, well, what am I monitoring against? Monitoring is normally against a set of agreed standards. There are no standards for out-of-home care in Tasmania; my understanding is, there never have been, and despite the recommendation at the time from Commissioner Morrissey, the standards weren't the first step; the first step was systemic monitoring, and the decision was then taken by Interim Commissioner Clements to implement, in the absence of standards, a thematic approach to monitoring based on the six domains of wellbeing.

Q. So, as you say in your statement, the systemic monitoring that you undertake has three elements: firstly, data monitoring; secondly, the thematic monitoring in the absence of standards and then, thirdly, what you've called responsive investigations?
A. That's right.

Q. Can I ask you firstly then about data monitoring? The Commission heard some evidence yesterday about the quality of data that's available from the Child Safety System and the out-of-home care system; what's the data that you get for the purposes of this part of your monitoring role?
A. I receive what we call a quarterly report, and they're usually retrospective, so I receive it, you know, months after the data is current, and that gives a range of indicators based around the six domains of wellbeing.

One that I can think of that would be of interest to the Commission is, I receive, for example, how many care concerns have been raised and how many of those care concerns have been substantiated, but I don't receive any information about the nature of the care concern. And the quarterly report includes the numbers of children in out-of-home care, the types of placements children are in, a range of information, and also information about the

throughput through the Advice & Referral Line. So, it gives us an opportunity to monitor the numbers going through the system.

Q. It sounds like it's certainly an opportunity, as you say, to monitor what us lawyers would call "widgets", thinking things out?
A. Yes.

Q. But to what extent does the data you receive let you get a sense of the quality of the experience that children in care are having?
A. It doesn't. Simply, it doesn't.

Q. Is there any other way that you are able to inform yourself about those matters relating to the quality of care?
A. Yes, they are. So, when we talk about data, I have a very relational approach to monitoring. So, in addition to the quarterly report data I seek additional very specific data to inform the theme that I am investigating at the time.

So, recently I wrote to both the Department of Communities and the Department of Education seeking a very broad range of information to inform that work. So, for example, I am seeking all of the reports into Special Care Package provision undertaken by the Australian Childhood Foundation. That request went off several weeks ago, I haven't had a response yet but I would expect one.

Further, I have established relationships with every provider of out-of-home care in Tasmania and, as providers move on and off that list, I introduce myself to them, I get to know them and their staff, and I meet with them asking a series of questions related to the particular theme that I'm monitoring at the time, and also to inform the theme that I may monitor at the time.

The theme that was already being monitored that I inherited was the theme of health, what it means to be healthy in out-of-home care. I think it's fair to say that I broadened that theme somewhat as a new Commissioner because I thought it was very important that the first report that I provided in out-of-home care included my view on the important overall systemic changes that were needed.

So, in 2019 I published the first monitoring report which, again, included a range of recommendations around the oversights that I thought were required in the system, again, included visitors program, again included the introduction of standards, accreditory processes, and a visitor's program.

Q. I take it from what you've said, Commissioner, that the colour and movement, the detail of what children's experiences in care are like doesn't come from the data monitoring, it comes from the work that you do in investigating the theme that's been identified for that year?
A. It does, and it also comes from speaking to children in care or with a care experience; that has been a very important part of monitoring for me.

Q. Do you get access to children and get the benefit of their experiences?
A. So, to start with you need consent of their guardian. So, the Department of Communities have provided me with a blanket consent to reach out to children and young people who are in care; I've extended that to children and young people who may have had a care experience, and through relationships with providers, through relationships with stakeholders, for example, the CREATE Foundation, the Foster Carers Association, with Tasmania. I have regular conversations with either groups of children in care or who have had a care experience or individual children in care who have consented to sharing their experiences with me.

Q. And so, the topic of the conversation with any particular child will be focused on the theme that is the focus of your work for that time?
A. Yes, that's right, I explain what my role is, which it still surprises me that many children in care are not aware of the Commissioner's role and I think that's a particular challenge for us, and our budget is fairly slim in relation to communications and marketing, so that is an ongoing challenge. But I explain my role, that I'm here about the system that cares for them, and that we want to make that system the best that it can be. I acknowledge that they are experts in their own lives and that system; they are an expert, I am not.

Q. One of the - and please don't take this as a criticism - but it seems that one of the potential disadvantages of

needing to use those six domains as opposed to a set of standards is that, if each year you pick one, then each one is going to get looked at every five or six years, and there's a risk, is there not, that the monitoring can't be as fulsome as it would be if you were monitoring each year to a designated set of standards across all the domains?
A. I absolutely agree, and in the 2019 report the recommendation I made included a two-step approach towards the accreditation of standards that was in recognition of that fact. With some more resourcing, not a huge amount, but some more, we could transition to a systemic monitoring approach based around standards which I think would be more beneficial, and then that could be an interim measure.

PRESIDENT NEAVE: Q. I just wanted to understand. In the conversations you have with children, for example, on health issues and I think the more recent one was being loved and wanted, a child tells you about something terrible that's happened to them, for example, which may not fit neatly within that theme. Now, your powers to do anything about that in those circumstances are pretty limited, aren't they?
A. That's right, I can't investigate that individual decision. So, my practice is to refer that information on to those who are best placed to respond and that can include the Secretary of the Department and/or the police depending on the nature of the allegation.

COMMISSIONER BROMFIELD: Q. I imagine you routinely get calls from parents or from kids to the office with concerns about quality of care, safety in care, decision-making.
A. Yes.

Q. What's the order? So, who would you suggest people go to first, and do you kind of outline, because there's a lot as we know in the regulatory space in Tassie; do you at that time say, go here if you don't get satisfaction, go there? What's the process that you tell a member of the public?
A. So, we do regularly receive calls. The calls we receive are often from people who have already had a significant amount of experience with the system, so they have already had experience with the Advice & Referral Line, they have already had experience sometimes with the Child Safety System and/or the out-of-home care system. So, sometimes they're well aware of the places they can go. Sometimes they have been there and they are dissatisfied

with the result, and depending on what they've done already, we provide them with further advice.

The most important thing that we do with public enquirers, in my view, is we listen. It's tools down for senior managers in our office who take these calls; we take them extremely seriously, and we listen once, twice, three, four times, and we continue to support people to get the information that they need.

How we refer people on has changed in my time as Commissioner. When I first began referrals were made from me directly, if necessary, to the Secretary or the Deputy Secretary of the department and also to the Child Advocate if there was a particular individual advocacy issue. Since that time the department has established a more central liaison point for the collation and collection of complaints, and I refer matters to that point who then, on my understanding, decides whether that information also needs to flow to the Child Advocate or others.

More recently in discussions with the Secretary I have again taken up the practice of informing him of particular matters that I'm concerned about, and he often takes quite a personal approach to following those up, of which I'm quite appreciative of.

Q. So, if I'm a parent and my child has been on a contact visit, told me something that makes me concerned about the carer; called your office, I know a lot about the Department of Communities from my perspective, they took my kids, I'm not particularly rapt with them as an institution. Would you refer me to that central contact point?
A. I would. I would ask you if you had contacted the Advice & Referral Line if you had concerns about the safety and wellbeing of a child, or if you had a reasonable belief that a child had been abused, I would also recommend that you contacted the police. In some cases that may have already occurred and people have been dissatisfied with the response of either, so I would inform them of the complaint mechanisms in both of those areas, the police and the Department of Communities, and I may also refer them to the Ombudsman.

COMMISSIONER BROMFIELD: Thank you, that's helpful.

MS ELLYARD: Q. Do some of the calls that you get, Commissioner, or contacts that you get, come from people who have an expectation that you've actually got powers to fix those problems as they perceive them?
A. Yes, that's right, and sometimes people get very angry and they get very frustrated, and there are times that I share their frustration.

Q. Because it sounds like, from what you've said and again this isn't a criticism, you'd refer those people largely back to the system they're concerned about?
A. Yes, that's right.

Q. There isn't actually an independent body with power as opposed to advisory functions to investigate concerns of that kind?
A. That's right, and I think another important point is, decisions aren't reviewable in a way that they might be in Queensland that we heard about this week. So, there's no mechanism there that someone can go to to actually challenge the veracity of the decision that has been made and perhaps even have a new decision made. I have, as other Commissioners have, made that recommendation.

The Government or the Attorney-General has advised me that they are willing to consider additional areas that TasCAT may have within its jurisdiction, of which out-of-home care may be one. I understand that the implementation timeframe for TasCAT has stretched and that that third phase of implementation, when that might be considered, hasn't occurred yet, so I'm certainly keeping an eye on that with a view to continuing advocacy for that to occur.

That in and of itself, if I just go on, raises more question: where would legal advice and advocacy for children who wanted to have a decision reviewed come from? At the moment the advocacy would come from the Child Advocate from within the department within which the decision may have been made, so there's a range of structural problems there that we would need to address.

Q. You've indicated that this year you're focusing on the theme of feeling loved and safe, and I'm probably not overstretching when I say that being safe from sexual abuse would come under that domain of being loved and safe?
A. Broadly, yes, it would.

Q. So you're investigating at the moment a theme which would include within its terms the extent to which children in out-of-home care are protected from child sexual abuse?
A. At its very broadest sense. I'll be very honest in saying that when we launched into this theme child sex abuse was not the main reason that we launched into the theme; it is one of a range of issues that can impact on the safety of a child.

I've also been very cautious in pursuing the concept of "loved" and "safe" within the out-of-home care environment, and we heard from an extraordinary victim-survivor yesterday how the concepts of feeling loved and being safe can be very tangled and entwined in an abusive environment and I'm very conscious of that.

Based on a literature review undertaken in the office we took the decision to explore the concepts of safety absolutely, but also the concept of stability and how that influenced the safety in a placement and the sense of relational stability that can be so important in a child's life.

Q. So, I take it then that, although sexual abuse and the risk of sexual abuse are included in the concept of safety and stability, the way in which you can do this thematic work doesn't really permit you to drill down into the details of the ways in which systems might be actively protecting children?
A. It certainly wouldn't allow me to deal - to investigate individuals' decisions that had been made in response to individual allegations of child sexual abuse.

Q. What about systems more generally in the sense of, for example, the extent to which there was appropriate training for people who were going to be working with traumatised children, the extent to which there were going to be Codes of Conduct for those who work with children; is that kind of thing something that you can draw into a thematic review?
A. Yes, that's right, and we would do that through data requests of both the Department of Communities and the Department of Education, and also through questions asked through monitoring visits of providers, but also monitoring visits of the Department of Communities separate to a provider as a provider, because they are also the system

owner.

Q. Perhaps I'm asking you for spoilers of what the report will ultimately be, but as you sit here today do you feel able to express any view about the extent to which the out-of-home care system does protect children against the risk of child sexual abuse?
A. I'm not going to spoil the report because the report isn't even drafted, we haven't even completed the analysis or indeed the collection of information, but what I have given a lot of thought to recently is the plethora of recommendations that have been made in Tasmania, particularly in relation to keeping children safe in institutions.

Recommendations have been made, as you know, by the Royal Commission, recommendations have been made by previous Commissioners, and recommendations have been made by me. I am now three and a half years into the job and my analysis of those recommendations based on my analysis of publicly available information and particular questions that I have asked of the Department of Communities leads me to believe that, despite the best efforts of Commissioners, advocates and Royal Commissions, there remain enormous gaps in the safety and oversight system for children and young people generally in Tasmania, but in particular in out-of-home care.

Q. I take it from what you've said, Commissioner, that it's not because the ideas for solutions haven't been given, somehow there's been some gap between the recommendation and the implementation. Do you have a sense from the role that you perform of it is that these recommendations haven't been enacted in Tasmania to protect children?
A. Again, I've given this a lot of thought, and I would add to what you've said to say, I think that many of the people working in the sector, be it in the department and/or the non-government organisations delivering care to children want the same things: they want carers' registers, they want standards, they want independent oversight, but there seems to be a gap in the ability to accept the recommendations of Commissioners and others, which the government have done, and then prioritise the development and implementation of those recommendations including through allocating appropriate resourcing to do so.

Q. You mentioned money last, but I take it that actually the availability of appropriate resources to give meaningful effect to recommendations is a key issue?
A. It is an absolutely key issue I think.

Q. Can I turn then to a discrete issue before I go on to ask - yes?

COMMISSIONER BROMFIELD: Q. Do you have any views about that? I mean it's a small state, there's always going to be pressures on the budget. This Commission needs to consider what's feasible for this state and what can be implemented and what are the top priorities. Are there recommendations that you think have languished too long that could have made things better that should be priorities?
A. I think standards for out-of-home care have languished too long, and even when I look at the most recent budget allocation for the implementation of standards, there's very limited funding in the first year, then there is funding in the second year, but it doesn't appear to me to be a level of funding that would enable the type of independent oversight of standards that would be envisaged, that I would have envisaged.

I think in a state as small as Tasmania it is always a difficult task to prosecute an argument that investing in children now will reap benefits for them and for all of us into the future. When I first became Commissioner it was very clear that it would - instead of focusing on an argument around, it's the rights of children that we should be upholding, therefore that's why we should be investing, people weren't listening to that. So, I instead evoked an argument of, if we invest in the wellbeing of our children now, it will continue - it will contribute to our economic prosperity into the future. The government did listen to that. So, it seems when things are couched in economic terms, which really saddens me, to be honest, it is more likely that governments will stand up and listen.

We now have a strategy to improve the wellbeing of Tasmanian children and young people; that's a framework on which we can hang all of these initiatives from, but I think we're having difficulty prosecuting the argument that the priority needs to be in investing in those oversight mechanisms now so that we can ensure their wellbeing into the future.

Q. Do you think there's examples of false economy where we haven't invested now and it's costing the state in terms of our most vulnerable children?
A. Absolutely. A body of work that I could refer you to was undertaken by The Front Project which estimates the cost of late intervention in Australia is in excess of $15 billion a year. You heard this morning the perfect example of the cost of late or wrong intervention. Mr Robinson bravely shared his story of how multiple systems in Tasmania collectively worked together to destroy his life, and on every measure of wellbeing that will have an ongoing cost to Tasmania.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Q. I've got one further question too. You've talked about the gap between accepting the recommendations that have been made, sometimes on multiple occasions, and implementing, and you've talked about the resource aspects of that. I wonder whether there are also pockets of resistance to change, cultural pockets of resistance to change. Do you have any comments to make about that fact?
A. Yeah, I think the pushback - and I don't think I'd describe it as pushback, I think it's more a well-intentioned focus on what is perceived to be investment in the frontline over and above investment in structural reform.

So, frontline work is extremely important, and you've heard evidence earlier this week about vacancies on the frontline and the pressures on that frontline system, and I completely understand, also from the perspective of children, how important those workers are. But reform requires more than investment in the frontline; it requires investment in data systems, investment in strategists, and investment in business systems that enable us to lift the performance of the system overall, and I haven't seen that type of investment in my experiences with the Department of Communities.

And part of my support of the machinery of government in structural changes to establish a new department is that, with the combined resourcing of the Department of Education and the Department of Communities, some of those structural impediments to resourcing a reform agenda may be

overcome, and some of those apparent inabilities to prosecute the argument to government or treasury to fund them may also be overcome.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. One particular recommendation if I can go to a very specific thing, Commissioner; a piece of work that you've been involved in recently was an expert panel which considered whether or not the state should continue to participate in the Many Colours One Direction program, and relatively recently that panel has reported.
A. They have.

Q. But as I understand from the material that the Secretary has provided us, there's still Tasmanian children in that program now; is that your understanding?
A. No, that is not my understanding.

Q. There's no-one there?
A. My understanding is that there are no children currently residing in the Many Colours One Direction program, which is a residential-type care program; that there are children remaining interstate but they are under different types of care arrangements, I believe a kinship arrangement exists for a child who may have been a resident of the Many Colours One Direction program.

Q. So I won't be able to get you to do justice to the recommendations of the expert panel, but the Commission heard some evidence, some strong evidence earlier this week from Ms Sculthorpe from the Tasmanian Aboriginal Centre reflecting about whether or not the use of the Many Colours One Direction program was ever an appropriate idea for Tasmanian children. What's your response to that?
A. So my view - I would agree with Ms Sculthorpe, I think removing children from their home, their state, their island state and their cultural connections is not necessarily in their best interests generally.

As Commissioner my view at the outset was that we should be able to facilitate an architecture of placements in Tasmania that catered for the needs of every child here. These are Tasmanian children, we should be able to care for them within Tasmania. My understanding is the only reason we were sending them to the Northern Territory was because we were unable to do so.

I was restricted in my ability to monitor out-of-home care, my power or my jurisdiction doesn't extend beyond Tasmania, so I can't seek information directly from Many Colours One Direction, but I did visit, I was invited to visit and I went, and I had no immediate concerns about the safety and wellbeing of children who I met there; indeed, they did appear to me to be thriving at that time.

There was some fairly, I think, tense moments between the department and I, and me attempting to exercise my powers and seek information in relation to the safety and wellbeing of individual children; I think I was pushing the boundaries of perhaps identifying individualised information. I received general information. I was then asked to be the Independent Chair of that expert panel, which I was very pleased to do because this was an issue that was so important to me, and in the process of the chairing of that panel I was provided with the type of information that I guess I was seeking in my initial requests from the department in relation to the care of individual children there and any concerns that had been raised.

Q. I'm struck by your reference there to some tense conversations.
A. Well, I found them tense; I'm not sure if others found them tense.

Q. And I would imagine that, given that your role is to advocate for the interests of children, it won't be uncommon for that advocacy role to bring you into - I don't want to use the word "conflict" - but into a degree of disagreement with other parts of the sector?
A. All the time, is the answer. I reflected yesterday on Penny Wright's - the Guardian from South Australia's evidence and this concept of always needing to renegotiate relationships to make sure your role - you're always operating in the best interests of the child in an independent way and the risk of regulatory capture.

It is a constant reality working in this space and working in a state as small as Tasmania. You've also heard evidence about the incredible power of relationships in getting things done. That's a double-edged sword.

Q. But also, I would imagine, the need to rely on

relationships because of a lack of legislative clarity about what your powers are must make the risk of relationships overburdening responsibility even stronger?
A. Absolutely. When advocacy deteriorates into a letter writing war between a Commissioner and departments, which is the risk that that's where it can end, I wouldn't argue that that's in the best interests of children at that time. And I have made decisions in my time as Commissioner to pull back from continuing to press because it was very clear that I wasn't going to be able to get where I thought we would be able to go, so pulling back enables you to renegotiate relationships and achieve things in a different way.

And I think in relation to Many Colours One Direction, the recommendations are there; again, the government have accepted them. I have recently written to the Minister outlining my concern about the budget allocation for the implementation of those recommendations because I don't believe it is enough or consistent with the panel's view that there needed to be whole-of-government investment.

Q. The Commission's heard from some witnesses, and indeed hasn't heard directly from other witnesses because of a concern that those witnesses had that, speaking too forthrightly about their perspectives of problems in the system or concerns about the system would be professionally damaging for them or professionally damaging for their organisation, and that the need to maintain relationships for the long-term benefit of children meant that they couldn't in fact advocate for children in the way that they would wish to to this Commission.

I'd be grateful for your reflection on this question of, when do you pull back from advocating for children because of the risk that you'll lose the relationships on which you depend to be persuasive.
A. I don't think I pull back from advocacy, I think I advocate in a different way. I have found one of the more effective advocacy mechanisms that I use is being curious, and learning as I go, and as you're being curious you can often ask about how that would align with our obligations under the United Nations Convention of Children, and that can often be a very effective mechanism rather than writing a dozen letters over a particular matter arguing a point.

Q. I want to ask you now some questions about the way in

which, as the Commission has heard, the Department of Child Safety investigates concerns about children in out-of-home care through the Care Concern process; is that a process with which you are familiar?
A. I'm familiar with the Care Concern process from a range of perspectives, and if you'd just allow me to explain. The first is the data I receive regularly from the department, I see the number of care concerns and the number that are substantiated and I can see the change over time, and I haven't observed a regular pattern in relation to that. I don't receive information on what those care concerns are about, how they have been investigated.

Q. Do you receive information about whether they have been investigated as quality of care concerns or serious abuse and neglect concerns?
A. No, I don't. Actually, I'll take a step back; I think I'd better check that, I'd better go back and check the quarterly report because there may be another measure that I've missed, so I'll get back to you on that but my current observation when I looked this morning was, I don't think so.

The other way I understand care concerns is, in my interaction with out-of-home care providers as a part of the monitoring program, and my understanding from their perspective in what they've communicated to me is that a care concern is raised by the department at the department level, and that can be in response to issues that are raised by a provider or by a carer, but there may well be a trail of information flow between the department or between the department and the provider preceding the raising of the care concern. So, I think the scope of what the care concern is or is investigating may not actually cover the full scope of information that has been raised in relation to that particular allegation.

This is something I'm very interested in, in the exploration of the theme of loved and safe, and I have sought to open a discussion with the department about how I can learn more about their transition to a new type of care concern exploration, which I currently know a very limited amount about, and how we can work together so that I might monitor that in a far more useful way than how I monitor it now.

Q. The Secretary has provided us with a copy of, as you

would imagine, a large number of policy documents, and one of them is a document that's called Responding to Care Concerns impacting on a child in out-of-home care which is marked as Exhibit 62 to Mr Pervan's RFS 23 statement, Commissioners. That document refers to, amongst other things, a Care Concern Monitoring Group that includes you. Is that a group of which you're aware?
A. No, I wasn't aware. So, this document is very old and, as you heard from Ms Enkelmann when she gave evidence, there are many documents as a part of the practice manual for out-of-home care in Tasmania that are quite old.

Q. Pausing there though. It's old but as I understand the evidence of Ms Lovell, it's still the document that is in force today in relation to care concerns; is that your understanding?
A. Well, it is the document that's there, but the structures of the department have changed so much that it's not clear to me which roles the document is referring to in relation to the examination of care concerns. Those inside the department may be more easily able to map old positions to new positions, but I'm certainly not. And you're right, it does mention me.

Q. And I take it then that you haven't ever been invited to attend a meeting of the Care Concern Monitoring Group?
A. No, I haven't, and my understanding is that the Commissioner that may have been invited was perhaps Commissioner Ashford at the time, and in looking over historical documents in the office, including some that I have provided to the Commission, it appears there was a process to provide a report to that group which included high-level information about the number of care concerns, the type of care that those care concerns had been raised in. And, having discussions this morning with people who have the corporate knowledge to be able to understand how that system worked in the office, I understand that there were meetings where those were discussed at a time but it was a very long time ago.

Q. And so, thinking about this theme of independent oversight over the way concerns about care are investigated, we've already talked about the fact that an individual who's got a concern doesn't presently have an independent body they can go to who could investigate a particular case; the only visibility you have over the Care Concern process is through the data that you receive and -

and I don't say this in a negative way - the anecdotal information that you might be able to receive through the relationships you've developed with out-of-home care providers?
A. That's right, yes.

Q. That seems a gap?
A. It is a gap, and what we're talking about is reportable conduct. So, if you look at this through the lens of a system that operates in Victoria or New South Wales, there are very comprehensive systems in place not only to investigate the concerns but to build the capacity of the organisations delivering services to be able to investigate those concerns themselves in a child-centred and best practice manner.

Q. Can I ask you, you mentioned that you don't have much visibility over this yet, but we understand from the evidence that Mr Pervan will give that the Care Concern process is to be overtaken by a newer process that's going to be called a wellbeing in care process. Do you have any sense of what that change in language signifies by way of a change in philosophy?
A. I think it signifies a shift to assess - well, this is my understanding, and my understanding is based on a presentation that I saw at a foster carers conference some time ago. I understand that it signifies a shift towards analysing the concern through the six domains of the wellbeing framework. Conceptually that certainly fits with other reforms that have refocussed our analysis of what is in the best interests of children to the six domains of the wellbeing framework, which I'm very supportive of, but that's as much as I know. I've sought a briefing and there's an agreement to provide me with that, and I think a general agreement that we can work together to form a system where I can monitor care concerns more comprehensively than I currently do.

Q. Thank you. Now, I'm looking at the time and I'm aware that in your statement you've commended to the Commission a range of structural reforms, including things like visitor programs, the existence of independent review. You've commended to the Commission the model that exists in Queensland for community visitors and advocates and so forth, and I know the Commission will have regard to those matters, but I wanted to ask you about a couple of points.

Firstly, one of the issues that appears to arise when we think about effective monitoring of out-of-home care is that at the moment the department is simultaneously a provider of out-of-home care, a contractor for services of out-of-home care, a decision-maker who should be in out-of-home care, and the person who assesses quality Care Concerns. What's your perspective on whether that's the appropriate model for something like this?

A. I don't think it really matters which lens you look at that through: whether you look at it through a systems lens or a classic purchaser/provider model lens if you put your economists hat on; it's not an appropriate model for service delivery and quality control. I made recommendations about this in my 2019 report that we really needed to have a better delineation about the role of purchaser and the role of provider.

I think it would be a big step to take in Tasmania to assume that the department was never going to be a provider of some sort because we are a very thin market. My view is, the department should be the system leader of provision. The department should be the provider who is leading the way for all others, and that there certainly needs to be other reforms in place to make that happen. So, for example, external accreditation of providers, including the department.

Q. And then the last point that I wanted to ask you about is a matter that you raise at the very end of your statement at paragraph 194 when you offer some reflections on, in the context of the need for independent oversight, of what you see as the need for a cultural shift perhaps in the State Service to make an independent oversight a successful model, can you tell us about that?

A. To put it really plainly, you can have all of the oversight bodies in the world that you like, but if you haven't resourced departments to be able to respond to them, and if in addition to that, departments are constantly receiving negative scrutiny through the media or through independent oversight bodies, it creates a culture of defensiveness, and I think I have experienced the culture of defensiveness, and through a relational approach, that culture can to a large extent sometimes be broken down but not always, and I think there will need to be a significant amount of effort made to ensure that people providing information to oversight bodies, be it me or others, understands that we're all working together;

this is not about me receiving information that I can then use against the government or the department, it's about everybody working together in the best interests of children to create the best system that we can.

Q. And where does the driver for that cultural change have to come from?
A. Well, I think what we learn through Child Safe Principles and what we've learned through the range of work that you've examined already, is that that culture needs to be organisational-wide and the culture of leadership across government is very important in driving a child-centred culture which, in my view, would include a culture of openness to oversight.

MS ELLYARD: Thank you, Commissioner. Thank you Commissioners, those are the questions that I had for Ms McLean at this time.

PRESIDENT NEAVE: Any questions?

COMMISSIONER BROMFIELD: No, I don't have any further questions, thank you.

PRESIDENT NEAVE: No questions I think. Thank you very, very much, Ms McLean. And, we will adjourn now for 20 minutes or so.

SHORT ADJOURNMENT

MS ELLYARD: Thank you, Commissioners, the next witness is Ms Sonya Pringle-Jones and I'll ask that she be taken through the formalities.

<SONYA BIANCA PRINGLE-JONES, sworn: [11.32am]

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: Q. You're here today because of the role you currently hold, which is the Child Advocate?
A. Yes, that's correct.

Q. How long have you held that role?
A. Since June 2018.

Q. We'll come to the details of what the Child Advocate role is but for now it's sufficient to say that it's a role

that sits inside the Department of Communities Tasmania?
A. Yes.

Q. Reporting to the Secretary?
A. Yes.

Q. You've made a statement to assist the work of the Commission. Do you have a copy of that statement with you?
A. I do.

Q. It was declared by you yesterday?
A. Yes.

Q. And you've attached a number of documents to it?
A. Yes.

Q. Are the contents of the statement true and correct?
A. Yes.

Q. I want to briefly speak to the background and experience that you have prior to taking up your current role. As is clear from your statement, you've had quite a long history of working in, broadly, the child protection sector; is that right?
A. Correct.

Q. And that's included roles as a Child Protection Worker?
A. Yes.

Q. It's included roles as a worker in residential care, I understand?
A. Yes, I failed to elaborate on that in my CV. I worked in residential care with young people in the UK in 2001, 2002.

Q. You also have a particular experience working in areas of trauma and child trauma, is that right?
A. Yes, I worked with the Australian Childhood Foundation for nine years after working at Child Safety in Tasmania.

Q. So it's clear that you are a very experienced practitioner, particularly when it comes to questions of working with children with trauma backgrounds?
A. Correct.

Q. And children who are intersecting with the Child

Safety and out-of-home care system?
A. Yes.

Q. You describe at paragraphs 13 and 14 of your statement what the purpose of the Child Advocate role is. We've heard about different Child Advocates through the evidence this week from other places, so can I ask you to summarise for the Commission what your work as Child Advocate in Tasmania is?
A. My role is, broadly speaking, to have oversight and monitoring of children's experiences in care in Tasmania, specifically the children who are in foster kinship and residential care and under custody and guardianship of the Secretary.

It is both individual and systemic advocacy, and in that vein it is in intervening in matters that have been referred to me, and anyone at all within the community can refer to me. Wherever there is a concern that the rights of a child are not being upheld I can look into that matter and become involved to a greater or lesser extent depending on what those worries might be, and the collective referrals that I work on feed into systemic advocacy recommendations. So, that's one component of the systemic advocacy.

The systemic advocacy work also entails facilitating youth consultation so that children and young people can actually feed into systemic change. There is also the work to ensure that we produce different resources, resources that children, young people and families can then use to navigate the system better, as well as a component of that role which is the capacity building of the system itself to better consult with children and young people.

Q. So, even as you describe it that sounds a lot, and at paragraph 17 of your statement the list of what you do is even longer. You're one person, do you do all of that by yourself or do you have a structure and an office that supports you in that work?
A. The office is me, myself and I; I answer the phone, I do all aspects, so whether it's - all communication, correspondence, report writing is done by me, plus all the interface with individuals that I might be working with, and up until very recently which was the recruitment of a Child Advocate liaison Band 6 across the north, north-west, I recognised for some time that my capacity to meet the

advocacy needs of children and young people across that region was compromised purely by geographical location.

Q. You say in your statement that you receive about 120 referrals a year and the overwhelming majority of them relate to children who are in statutory orders and living in out-of-home care?
A. Yes.

Q. I take it that, once you receive a referral, there's a range of steps that you might take, some more advanced in some cases more than others to analyse what role there is for you. Do you always meet with the child who's the subject of the concern?
A. No. No, I directly interact with children probably on 30 per cent of those referrals. More often than not, and dare I say practically 100 per cent of the time, on a referral that requires detailed work the common denominator is that adults aren't seeing eye-to-eye. So, often that is - the effort and the energy has to go into trying to reconcile points of difference: why does one person have a different view on what's in the child's best interests to another person, so that can often be a bulk of the work.

Q. And, as we understand from the reports that you've attached to your statement, examples of the kind of work you might be involved in are when there's a dispute about the speed of reunification, for example, or a dispute about the extent to which a child's wishes in relation to contact with birth families should or shouldn't be respected; that's a couple of areas?
A. It's incredibly broad. Every single referral is unique. Every single referral, I believe, requires an individualised and nuanced approach into how particular steps in the work need to be undertaken, and that might be the sort of approach that I'm taking to help others embark on that process, of more creative, more individualised, being able to be more inclusive with all the relevant people for that child, and including the child, is often the core theme that then permeates all of that work.

Q. And so, I take it what's common to all of the referrals that you receive is that there's decision-making happening in relation to a child and there's some degree of dispute or concern about how that decision-making is taking place?
A. Correct.

Q. Whether that's because the child's not being heard or whether it's because two different adults of significance in the Care Team in the child's life can't agree?
A. Yes. And I think I tried to summarise it by saying that my work could broadly be considered to be helping adults understand what the child might be saying, and I think Mr Robinson's testimony this morning really says that; throughout his experience that he's recounted was evidence saying, there was just a failure to understand what he was trying to say; instead it was a judgment that maybe he was being naughty or, you know, but that behaviour was communicating his distress.

COMMISSIONER BENJAMIN: Q. Sorry to interrupt you. How would he know today? If he was in that home, that 13 or 14-year-old boy or 12-year-old boy, how would he know you exist?
A. In early 2020 I broadly sent out all communication - communication to all 1300, which included children and young people on third party guardianship received information, so there was a saturation in early 2020 through an actual mail out that provided details of me, what the role is designed to do in a child-friendly approach, as well as providing them with, these are the current steps around how you can make a complaint, because we'd never broadly communicated that, but all service providers, all people in the sector know that this role now exists.

So, if a child was in that home now there would be the Charter of Rights on the wall, there would be information that gives them access to me, the staff in those homes know that I exist, and with the Commissioner for Children and Young People we are still working to try and introduce a visitor program within the current existing resource, so that enables us to have visits and meet and greets with young people so that we become more familiar as well.

Q. That depends, of course, on a child, (1) being literate?
A. Yes.

Q. We know in Tasmania the rates of literacy aren't as strong as perhaps they could be and, secondly, that the carers would tell them. Because on my calculations, and I'm not being critical, I'm looking at this in terms of --

A. No, that's right.

Q. -- you get about 120 referrals a year and you see, I think you said, about 30 per cent of those.
A. Correct.

Q. So you're seeing somewhere - and there's about - I mean, there's two numbers we look at, there's the 800, there's the 1300, but roughly say a thousand kids, so you're seeing about 4 per cent, 3, 4 or 5 per cent of the children in care each year, aren't you, so they know you as a face or as a person?
A. I think that what's probably the main part to emphasise is that almost always the person who is making that referral to me is the person that is of a child's choosing, that there is someone - and children will often say, "My carer is my first line of advocacy", so I need to rely on adults, whether professional, not professional, caregivers, family members, knowing that this role exists through various means, and the actual referral process to me is kept incredibly simple; it's just a phone call directly to me, there's no filter in that. It could be through social media that a child could make contact. There's information on a departmental web page; it's kept as broad and as simple as possible in recognition of that, some of those limitations that exist.

MS ELLYARD: Q. The Commission has heard some feedback from children who were interviewed on behalf of the Commission by Associate Professor Tim Moore which included at least one child, the Commissioners would recall, who said that she rang you directly and you sorted out her problem but she reflected that that might be a scary thing for someone younger than her to do, so clearly there's a difference about the capacity of older children as opposed to younger children to seek your services directly?
A. Absolutely, and I think I take whatever opportunity I can to then be in sort of broader forums such as foster care gatherings or, as I mentioned before, the attempts by the Commissioner and myself to actually be directly going into the residential care homes as well.

PRESIDENT NEAVE: Q. What about schools, because kids will often go to a teacher or something, so do you do any education of teachers about your functions and role?
A. The only - there have been - since the role's inception there has been an attempt to try and cover off on

every, sort of every domain that sits around children. I did do a broad presentation to all school social workers and psychologists; from memory, that was just before COVID and it was to roll on across the state, yeah.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. One of the things that you say in one of your reports, it's a report that's been marked as Exhibit 9 to your statement and it's your bi-annual report for January to June 2021, is that you describe that in that cohort of period of time a significant proportion of the individual advocacy work that you'd done related to advice given to professionals on how to encourage children to participate in decision-making and to support professionals to reflect on. It sounds like a big part of your role is not necessarily trying to - you don't make a decision, but you're providing advice on how decisions should best be made?
A. Absolutely, that is a core focus and I'm doing that at all layers depending on - and by that I mean, I come in and intervene at multiple layers within the service system, and such is, I think the benefit of the role not sitting inside the portfolio of Child Safety in out-of-home care services, but to the side. So, I can come in on any particular issue, provide advice and guidance, whether that's on an individual child's matters or by thoroughly taking a procedure that's in draft to task and really unpacking it.

So, I recognise there is the conjecture around the role's location, but I think there is so much influence that's brought to bear internally within the house because of the way the role is designed that many outside wouldn't see.

Q. As I understand it sometimes the work that you do will involve meeting with the child and perhaps working quite extensively with the child doing things that a Child Safety Officer could themselves do but for whatever reason you take the view that it's work that you should do speaking directly with children; is that right?
A. Yes. I think, when you look at the detail of what the statement of duties requires, it's so broad to even just be saying that the role needs to endeavour to increase the satisfaction of children's experiences in care. If there were in some way, through my assessment, a need to infill something there, then I feel an obligation to do that, but

that's a very delicate balancing act because I also can't perform the role in a way that's potentially plugging systemic gaps either because that's completely unsustainable.

Q. And that's what I wanted to ask you about, because it does seem that a large part of the way you ensure children's voices are heard and improve their satisfaction of the system is by upskilling the people who are doing the frontline work with them?
A. Correct. As I've written in my witness statement, often something I might repeat is that we are all advocates for children when we work effectively with them. So, yeah, very often I will be helping to, you know, provide that upskilling and hence seeing that on an individual case-by-case basis and the influence that I can bring to bear in those individual matters which, you know, that was what fed into, I need to actually write a training package; I need to be able to be in a room with 20 or 30 professionals and share these messages so that they can be able to fully unpack, well, what are things that might even act as barriers to our engagement with children; we need to really deeply reflect on why those things exist.

Q. And so, that sounds like in many ways you're doing the kind of work that in other contexts might be called the work of a principal practitioner or a practice advisor, that is, a senior experienced practitioner mentoring, coaching and writing procedural advice for frontline staff?
A. Correct, and again, if you read the statement of duties there are aspects of that that are speaking to needing to do exactly that. So, again, it's that, the complexity of, you know, how does the role work across all these areas.

Q. I take your point that, if that's the kind of work you're doing, it's work that can really only be done from inside the tent, as it were, from a position where you're perceived by the people that you're coaching or mentoring to be on the same page or in the same team, but it means that in a real sense your work is able to be successful because they don't see you as independent, they see you as part of the team?
A. Absolutely, and I think - and I speak to that in the witness statement - depending on what I am interacting with a professional about, it's quite apparent: they'll either experience me as someone who is a supporter and a guide, or

if it's on an individual matter where I have concerns that the practice could have looked different, they might experience me as a critic or as a disrupter. So, I think that's difficult for people to, you know, move between those extremes at times.

Q. But it does, as I think you acknowledge in your statement, raise the perception or the potential for a perception or a concern that the role can't really be an independent role when it sounds like a lot of your success depends on teaming up, in a good way --
A. Yes.

Q. -- with the people inside the system?
A. Yes, I think, as I say, the only currency I have in this role is relationship. And, to quote a trauma expert, Kim Golding, who in providing advice to parents raising children who have experienced trauma, she'll provide advice that, "It's connection before correction". I'm applying exactly the same principle in my work with Child Safety officers.

The benefit of being in the house, so to speak, is that I'm not in the hub of it by any means, but I'm in a room off to the side of it, so I'm acutely aware of how it's operating and what influences are coming in, and that is precisely what gives me the capacity to inform systemic advocacy recommendations. If I was down the road and around the corner, I'd have no idea, and I also think it's in recognition of the fact that there are other systemic advocacy functions in the Commissioner for Children and Young People, the CREATE Foundation. So, I think we need to be able to look at what then are the unique things that this role can bring to bear by being inside the department.

Q. I take your point that in that one sense anyone who's working with children needs to be an advocate for children and, no doubt, in what you do you advocate for children; but one of the limitations, as I understand it, from your role is that, as you've said, that the power you have is the power of relationships, you can't be a decision-maker; is that right?
A. Correct.

Q. You can't change a case plan decision or a decision that's been made by a worker or a team leader other than by persuading them to change it themselves?

A. Yes, but I would like to think I have a degree of success in doing that persuasion, but again, probably one of the limitations of the role which I have unpacked in the witness statement is, I haven't had the capacity to implement an evaluation mechanism, so that sits uneasily with me; that I'm yet to embark on getting formal feedback because, if people do consider that there is a conflict of interest by the role being internal, then I need to know that, we all need to be looking at, well, how can it work differently or better then if the work is being experienced.

Q. Or should it be re-categorised as the role of a principal practitioner with the function of making it more explicit that the way you achieve better outcomes for children is by being a coach and writer of policy, improvements and training?
A. It's interesting because I think the role definitely does not need to sit within the delegated hierarchy; that automatically detracts any capacity for it to be experienced as independent. So, that is one part of the role that I guess is something that I perform, but because of the combination of its other facets I can sit in a way that I literally have a foot in both camps of internal and external and I can oscillate between them in a way that brings a balance to whatever the issue is that's needing to be done.

And, as we've already discussed, there's a degree, I hope, whereby people can approach me because they have that sense that, she's not - you know, she can access all information very nimbly; there are no barriers for me to be able to do that and I think that's one of its huge assets. So, there's no filtering, I can absolutely access the system and have full capacity to assess with a lot more rigour. But by the same token I can access all areas externally as well without any limitation.

Q. Do you have any involvement in the Care Concern process? Have you ever had an experience of being called in or referred a matter where part of what was going on was the investigation of care concerns?
A. Yes.

Q. What role do you play in those kinds of cases? Do you work as part of the Care Concern process or outside it?
A. Absolutely become a part of it and very much in the

role of Child Advocate. So, it is in ensuring that whatever the circumstances that have given rise to that care concern is something that we are able to assess and really scrutinise in a way that is guiding what the next steps are to be taken with the most degree of care possible. Because, if we're very child-centred in how we do that, we limit any harm that may ensue; we're able to ensure that those steps are not too prescriptive - and I hope that doesn't get taken the wrong way - but that they are nuanced very sensitively for that child.

Q. You've given an example in one of your published reports of two children who needed to be removed from placement because there was a concern that just meant that that had to happen, but that the work that you did involved helping them understand that process and have it managed as sensitively as possible; is that an example of being involved in a case where there's a care concern?
A. Yes, absolutely. Absolutely.

Q. One of the things you say is that the individual advocacy then informs the systemic advocacy that you do through the writing of reports and the making of recommendations to the Secretary and to the department about systemic things that it appears to you from your frontline work should be changed, and you deal with that at paragraph 55 and following in your statement, and you make the point that in collating all of the reports together you've observed how your reporting has changed over time.

Indeed, you say that you've made some recommendations a number of times and basically stopped making them because you thought, well, the government knows about that, and on one view that might suggest that the government hasn't heard you or has - and I'm interested in your reflection on why you would stop making what obviously you thought were appropriate recommendations just because you felt that they were being made over and over again?
A. Absolutely. I don't believe that it was that they weren't heard, I just considered that there was not much help in repeating what other bodies or reviews or whatever have actually already said. Instead, I can potentially give a different spin on that from a practitioner point of view, or by being able to see the intricacy of some of the interlinking parts because I'm inside, to take it to a different level, to take those recommendations in a different way that helps to inform practice to shift it

rather than it being experienced as recommendations that might be just like other entities which can provoke an unhelpful response at times. So, yeah, it needed to shift.

Q. This raises a question of culture, and I don't know if you were present for the evidence of the previous witness, Ms McLean, the Commissioner for Children and Young People, and it seems that some of your reflections are that you're able to work as well as you do because you're perceived as being inside the tent and so people don't get defensive - my word, not yours - and it sounds like in what you've just said as well, you're able to make targeted recommendations that land more gently with people because you're from inside the system. That seems to carry with it an assumption that there's a defensiveness and a resistance to change if it's suggested from the outside; is that your observation?
A. No. No, on the contrary, I think the recommendations that might come in from externally are absorbed and integrated into existing change processes to the best of their ability in line with, well, we're already on this train track but it's like you get something else that comes in, it's like, well, hang on, we've got to go here now because we're obligated to and we've said that we'll implement them, but it's that experience cumulatively over time, and I've now seen it for almost two decades in this sector in Tassie that I think causes us to, or potentially creates the environment that runs the risk of it just becoming chaotic change.

I think that what's unhelpful is that as an organisation or that - that is experienced as threat and we're sort of seeing a cascade of an accumulative harm occurring within the system.

PRESIDENT NEAVE: Q. Can I just follow up on that. You said that there were some situations where, and Ms Ellyard has taken you to this, where you decided that you won't keep reporting on earlier recommendations, but you also said that there might be a way of getting there in another way. Have you got a specific example of the way that - of where you've done that? So you've got a recommendation in place that's been made, hasn't been implemented, but you've managed by your influence on people internally to somehow give effect to what was intended by the recommendation?
A. I think what I've listed in paragraph 58 has to a greater or lesser extent, and I certainly wouldn't want to

be presumptuous to think that it's just been my recommendations that's caused this work to take place, but largely I think it's the presence of this role within the department means that there's almost like an opportunity, even if it's something as informal as a water cooler conversation for exec to marinate in these conversations more often. So, rather than it's seen as a separate piece of work, that this is the to do list on that particular review of recommendations that we're implementing, it's because of something that is - because of those collegial relationships where I can continually keep coming back to.

And just looking at that list, I would suggest that the care team and care planning change processes for us to be able to improve practice around planning and decision-making processes for children, I've had a significant body of influence in that.

The strategic alignment of projects, I think that's probably been an area that, again, I've just kept coming back to. We have to improve the efficiencies of how different change processes are being undertaken and see the commonalities in them and link them better so that they actually can be implemented more effectively and successfully, so that's probably something else I've just kept coming back to, but yeah, from that section there's probably a number of other examples I could use.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. In practice, Ms Pringle-Jones, it seems that sometimes people come to you effectively because they've got a complaint which you're able to solve for them through advice and good practice, but one of the things you note in your witness statement is that there isn't actually a complaint function of the kind that you think there should be for children and carers to use if they have concerns about children in care?
A. Yes. This causes me concern. I think before producing the flip card that went to all children to explain the existing complaint process, the consultation that I had with young people in creating that resource was - it was very clear; they're saying that the existing complaint process is not child friendly, this is not conducive to approach the department. So, I think that's one of my recommendations that I have continued to emphasise as is reflected in my witness statement. It is

something that I know the department have - it's actually written within the publicly available strategic directions for the 21 to 24 years, and there is already work that we know is on task to do.

MS ELLYARD: Because it would seem to be, firstly, a key element of a child-centred organisation but a key part of a child's right to participate that they know how to exercise a right that the system gives them to make a complaint about their experiences in care?
A. Absolutely. I think, you know, when I sent that information out in early 2020 it was obviously just to be broadly publicising the role, but I was loath to do that without it actually including as well, "and this is the complaint process as it currently exists" because we hadn't ever done that before, so it was such a fundamental thing to do in recognition of what it is to create a Child Safe Organisation.

Q. But it sounds like, even though you explained the process in as simple language as you could, you would say that it's not really a good process at the moment?
A. I think we just need to be able to hear that children and young people said, this is not conducive for me to approach the department directly as per step 1, go to the Child Safety Officer or team leader. It was not approachable for them, so yes, we know that that needs to look very different.

Q. The last thing I wanted to raise with you, Ms Pringle-Jones, because I'm conscious of the huge detail that you've given us in your written statement, is the reflections that you've offered in your most recent report which has been summarised at the back of the document that's been marked as Exhibit SPJ-13; this is the collation of your systemic recommendations, and you offered a long reflection under the heading, "Direct advocacy creating stability and chaos" as part of the report that you sent out for July to December 2021. And I think you've already touched on some of the things that you have said here, but I wondered if I could get you to reflect on what you've identified through your time in the role as the fundamental issue afflicting the organisation of Child Safety and the impact of that on Child Safety's ability to do the work that people in it want to do?
A. I think one of the core things that I'm drawing attention to in that piece, which is actually something

that's still going through its internal motions of passage, it's not actually being shared with those external such as the Minister and the Commissioner for Children and Young People yet; within that piece I've written the influences that we can see that are taking place that are coming in onto an organisation that is a traumatised one; the system itself manifests the signs of impact of trauma. I think what it is imperative for us to start looking at is, well, what are those influences that are coming in, because whatever sort of criticism that they may be bringing to bear has to be understood in terms of the limitations it's placing on the organisation to overcome its own traumatised space that it's in.

Q. One of the things you say in that piece is that it's been your observation that the attention of people is often drawn away from working on things, it's drawn away from looking - to turn around and answer, whether it be to politicians or anyone else for perceived failings so no-one can get on and do the work because they're constantly being called to account or asked to explain themselves for what's happening?

A. Correct, and having written that in that particular piece in my report I've also reflected on it in the witness statement. I see it almost to a perverse level that you see this leadership with a strength and a wisdom to actually do the work that's required, and they're constantly being pulled away from it to face this external noise, and I'm not quite sure that for others outside the system that they can actually see the extent to which the operational leadership is constantly pulled away from actually implementing the changes that are required.

Q. You make the point certainly in the written piece that some of those external influences like the Ombudsman or the Coroner of course are essential, but what you're drawing attention to is the level of ministerial or political interest that might operate to pull people away from doing the work?

A. Yes, that's one of them. Another one would be the media. I think we need to recognise that for the staff internally they are interfacing with trauma in the field with the children and the families that they're working with, but that it's also - it comes down internally from forces that sit higher and outside the department, but it also might come from the side as well and we need to better understand those influences so that we can be genuinely

recognising how power structures actually influence the ability for individuals to listen to children regardless of what that role might be within the system.

The influences of power cause adults to feel a degree of discomfort and that pulls them away from then sometimes being able to genuinely listen to a child, or indeed that the due weight that needs to be given to the child's views is eclipsed by the discomfort of adults. And I think, you know, that's what I see permeate both individual and systemic matters that I'm trying to bring more attention to to understand those influences.

Q. And so, what do you think the solution is to that? It's a big question, but what you're identifying is the extent to which a department doing important work is being hampered in its ability to do important work and to achieve necessary change because of, this is my phrase not yours - constantly having to look over their shoulder or be pulled by the shoulder to comment on or be accountable to external bodies? From your point of view what can be done to change that?

A. Well, it's multi-faceted. I think in its most beautiful way we need to be able to ask ourselves, well, how would the system be designed if children got to design it? I think it would be massively simplified and pared back and less focused on the needs of adults.

And, there is reference to it in my witness statement around, how do we actually design the best system based on what we know to be best practice and then do a cost analysis of, well, how much does that cost and fund that. Not, here's a bucket of money, get your change to fit within that budget: perhaps that's one answer.

We do need to be able to ensure that the corporate structure has sufficient capacity within it in terms of personnel who hold all these different roles so that a leader isn't pulled to answer to external stuff to the same extent that they are and they can be operationally leading.

I think that there is a need, and it's the very reason I've written that piece of creating stability in chaos: we actually need to be more able to start naming up the elephant in the room around power structures, and that's not just within the Child Safety System, I think that's broadly within our community. Adults have an incredible

ability to overpower children, and that's been throughout time, but what a Commission such as this and all of those that have been before, et cetera, are trying to bring to bear is that children have rights that are being overshadowed by adults' rights, and until we can understand the very nuances in our cultural thinking, beliefs and values that enable adults to overpower children that way, then we're failing to sort of air this cultural issue, and so, I think that that's - yeah, that's why I wrote that piece, is to start airing it, we need to start talking about these powerful influences more on children.

Q. And I know you said it hasn't been disseminated widely, but obviously that piece has been disseminated to some extent within the department?
A. Within the department it has.

Q. And, how do people take it?
A. When I first drafted it I sent it to approximately a dozen colleagues of senior standing, and there is no disagreement on that being an influence at play that is negatively impacting on work, which then garnered me to obviously refine it and finalise it. If there was dissent around, no maybe not, then perhaps I would have erred on not writing it. I think it is - yeah, given that I think it is what we see, it's important to start talking about it.

MS ELLYARD: Thank you, Ms Pringle-Jones. Thank you, Commissioners, those are the questions that I had for this witness but I'm conscious that you may have some.

PRESIDENT NEAVE: Thank you. Any questions?

COMMISSIONER BROMFIELD: In the interests of time I'll leave it, thank you.

COMMISSIONER BENJAMIN: No.

PRESIDENT NEAVE: Thank you very much, Ms Pringle-Jones, for your evidence.

MS ELLYARD: We're proceeding immediately on with the next witness, Commissioners, and I'll call the Secretary, Mr Pervan, into the witness box.

PRESIDENT NEAVE: I need to make a restricted publication

order in this context.

MS ELLYARD: Yes.

PRESIDENT NEAVE: The Commission will make a restricted publication order in relation to the evidence of the next witness, Mr Pervan, in order to avoid identifying relevant people.

In the context of the scope of this inquiry the Commission makes this order because it is satisfied that the public interest in the reporting on the identities of certain people who may be discussed during this hearing is outweighed by relevant privacy considerations.

The orders contemplate the use of pseudonyms in relation to a number of people. Any information in relation to the identity of those people must be kept confidential. This means that anyone who watches or reads the information given by the next witness must not share any information which may identify the people who will be referred to, and these are the pseudonyms, as: "Adriana, Cora, Dennis, Edith, Etta, Ivan, Linda, Nancy, Orson, Wanda".

I'll make the order which will now be published. I encourage any journalist wishing to report on this hearing to discuss the scope of the order with the Commission's media officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

Thank you, Ms Ellyard.

MS ELLYARD: Thank you, and I ask that the witness be sworn.

<MICHAEL PERVAN, sworn: [12.13pm]

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: Q. Thank you, Mr Pervan. Can I ask your full name again?
A. Michael Pervan.

Q. And you are the Secretary to the Department of Communities Tasmania?

A. I am.

Q. And you've had that role since 2019; is that right?
A. Yes, September.

Q. But prior to that you've had a long career in senior positions in government?
A. Yes.

Q. Both in Tasmania as the head of the Department of Health and Human Services and in the hospital context as well?
A. Yes.

Q. You've made three statements so far to assist the work of the Commission and they've been numbered in response to requests for statement 18, 21 and 23. Have you got copies of all of those statements in front of you?
A. Yes, I do, thank you.

Q. There's a degree of overlap between them and we're not going to cover everything, but are you content to proceed on the basis that the contents of those statements are true and correct?
A. Yes.

Q. Thank you. As I understand it, you've also been provided for the purposes of your evidence today with some de-identified case study examples; is that right?
A. Yes, I have, yes, thank you.

Q. You've had an opportunity to look at them?
A. I have.

Q. And we'll come on to them a little bit later.
A. Thank you.

Q. Just to go again briefly, Mr Pervan, to your professional background. As I understand it, you were previously the Secretary of the Department of Health and Human Services from 2014?
A. Yes, that's when I started acting in the position.

Q. And at that time Child Protection sat within that department?
A. Yes.

Q. But then later on when the Department of Communities was formed in July 2018, that section went out from your portfolio and across to Communities?
A. Correct.

Q. And you've now moved to take it up again?
A. I was moved, yes.

Q. And so, that means that for most of but not all of the past eight years or so the Child Safety Service has been part of the portfolio that you've held as a Secretary of a department?
A. Yes.

Q. And so it certainly wasn't new to you when you came across to the Department of Communities in 2019?
A. No.

Q. As I understand the statement that you've given us - and the reference point, Commissioners, is Request For Statement 21 at paragraph 21. The department at the moment is structured with five divisions: yes?
A. Yes.

Q. One of those divisions is the Children, Youth and Families Division, it's led by a Deputy Secretary?
A. Correct.

Q. Inside that division there are two service streams, one of which is the Children, Youth and Families Division - one is Children and Family Services?
A. Yes.

Q. And inside that sits, relevantly for our purposes, the Child Safety Service and the out-of-home care service along with a number of other programs?
A. Yes.

Q. And so, as we understand from your statements the out-of-home care department of Department of Communities sits inside and is part of the Child Safety Service?
A. The out-of-home care function, yes.

Q. And the out-of-home care officers are part of the Child Safety Service?
A. Yes.

Q. I wanted to just begin with some questions to orient us about the number of children that we're talking about when we speak about children in care and I want to begin by bringing up a document, please, on the screen which is a document that you've provided as attachment 36 to your witness statement, RFS-23. The reference is TRFS.0023.0048.0036. I'll just ask that we zoom in on the bottom table. This, Mr Pervan, is the information that you've provided us as part of your statement about the number of children in out-of-home care over the past few years and the most recent record that was available at the time you made this statement was a point in time figure at 22 April 2022?
A. Yes.

Q. And that figure is 1,034 children?
A. Yes.

Q. Thank you. And then if we go over to the next page again, please, Madam Operator, and again go down to the bottom table at the bottom of page 2, we see there a breakdown of the children by kind of care?
A. Yes.

Q. And, as you've made clear in your witness statement, most children live in Family-Based Care, that's kinship or foster care; is that right?
A. Yes, correct.

Q. And so, on the far right-hand side we see 968 children in that kind of care, 61 children in Salaried Care, four in independent living and one in another living arrangement?
A. Yes.

Q. And you make it clear in your statement that, looking at the cohort of children who are in Family-Based Care, about 72 per cent of those children live in placements organised directly by the department and 28 per cent through placements organised through non-government organisations?
A. Yes.

Q. All of the Salaried Care is provided by non-government organisations?
A. Yes.

Q. That can come from the screen please, but I wanted to

just ask a point of clarification, Mr Pervan, because if we look to the dashboard that your department maintains that gives an online snapshot of the number of children who are in out-of-home care the figure's different and I want to understand why that might be. So, this is what the Department of Communities Tasmania, Human Services Dashboard looks like at the moment, and if we look on the right-hand side there under where there's a box, "Children and Youth", there's a different figure for children in out-of-home care of 1,256. Do you see that?
A. Yes, I do.

Q. If we click on the "more" button, we can see there that there's a table about the number of children as at the end of each month that are in care. That's obviously a higher number than the number that you've given us. Are you able to tell us who the children are who are in this heading but are not in the figures that you've given us?
A. No, I'm sorry. What I'll have to do is actually get that looked into. It could be --

Q. I'm sorry to interrupt you.
A. No, in my experience, because these sorts of questions come up during Parliamentary estimates quite a lot, it's due to a different point of time in the census dates when we provided that information through to the Commission as compared to when the dashboard figures were updated.

Q. I wondered whether, and I'm drawing your attention, and perhaps we need to zoom it up so that you can see it, whether the answer might be that these figures are including not just the children for whom you're the Guardian but also children who are on Third Party Guardianship Orders?
A. It may well be that that's the explanation, yes.

Q. And so this comes then to the question of what we mean when we're talking about children living in out-of-home care. Your figures, as I understand it, relate to children who live in out-of-home care under your guardianship but perhaps there's a larger cohort which include children for whom you don't have a guardianship role?
A. That would be correct, and once again this is an issue that comes up quite frequently and it goes to data definitions and the difference between how we monitor care and how we responded to the Commission and the Australian Institute of Health and Welfare data definitions that we

comply with, so you end up with different datasets which makes it, I understand, very confusing for people trying to understand the extent of the system.

Q. That can come from the screen, Madam Operator. But obviously from the position that you hold there's a need for absolute clarity about the number of children for whom you have guardianship responsibility in out-of-home care?
A. Yes.

Q. Because you're effectively their parent?
A. M'mm.

Q. And I take it, may I take it that the figures you've given us in the witness statement are the best figures that you have of - or the most accurate figures you have of the number of children for whom you have parental responsibility?
A. Yes, and considerable time and effort was put into making sure those figures were correct.

Q. Thank you for raising that because we understand from the evidence of Ms Lovell that perhaps there's even been a recent addition to staffing in the department to deal with precisely this question of achieving clarity about foster households and the number of children in care, is that right?
A. Yes.

Q. And it follows, I take it, that there was a concern that the records weren't accurate?
A. My understanding of the concern was that it wasn't so much the records weren't accurate, because they weren't, it was more the lag between children coming in and out of care and how long it took to process that information onto the database.

Q. So that a snapshot might be inaccurate because there were new children who'd come in or children who'd left care whose records hadn't been updated?
A. Yes.

Q. So it's a timeliness issue rather than an accuracy issue?
A. Yes.

Q. The out-of-home care system and the Child Safety

Service system more broadly are, I would take it, the mechanisms by which you exercise your parental responsibility for children who are in your care as Guardian?
A. They are the systems but how I exercise my authority as Guardian is through a combination of a very substantial instrument of delegation; it's 54 pages long and details where exactly in the structure of the Child Safety Service and out-of-home care generally my functions as Guardian can be exercised in order to put the powers such that I have and the functions as close to the child and family as possible. So, as decentralised as possible, I should have said.

Q. And no-one would suggest that you could make individual parenting decisions for a thousand children, that wouldn't be feasible at all, but the system that's in place, supported as I understand your evidence by a careful system of delegations to carry out your parental responsibilities, is the structure of the Child Safety Services and out-of-home care system combined with relevantly the contracts that have been entered into with private providers for care of some children?
A. Yes.

Q. Thank you. May I ask you some questions briefly about the extent to which you've had the ability to follow the evidence that has been called this week? You're a busy person, but have you been able to see any of the evidence?
A. I have followed the evidence all week, yes.

Q. And, has that involved having the opportunity to watch it directly or to be briefed by those assisting you on what the evidence is?
A. No, I've watched directly all week.

Q. So you saw the experience, for example, of the lived experience witnesses that we heard yesterday and today?
A. I did.

Q. And you heard read into evidence the experience of the other lived experience witness, Faye?
A. I did, yes.

Q. And you've seen, as I understand it then, the evidence of Ms Lovell who is your Executive Director?
A. Yes.

Q. Do you agree with her evidence?
A. Yes, absolutely.

Q. And you heard the evidence from other people, including evidence of people who work in foster agencies or have previously worked for you in Child Safety Services?
A. I did, yes.

Q. Did anything about the evidence that you've heard this week so far surprise you?
A. So, if I may?

Q. Yes.
A. My experience outside being a senior administrator goes back to my time in WA when many years ago I was the health liaison to the Royal Commission into Family Violence and Child Sexual Abuse in Aboriginal Communities that was chaired by the Magistrate Sir Gordon. To say that these issues surprised me, sadly, no they didn't. Was I confronted and shocked? Yes, I was.

And before I go on, I'd like to repeat, because I can't think of any better way of putting it, the words of the Premier when he said that:

We are so terribly sorry that we failed those people, our system failed those people.

Particularly for the lived experience witnesses today, and Azra, I am so sorry that we were not there for you.

The wellbeing framework that we're now implementing was driven by the Department of Premier and Cabinet but by a team embedded in the Department of Communities Tasmania where they still are, and I have been a very strong supporter of that work since it first began.

The fact that people in our systems did not feel loved and safe, I think, is a tremendous tragedy, and especially to Azra who was calling for it, I would sincerely and genuinely want to say that we're so sorry that the system let her down so badly.

Q. Thank you, Mr Pervan. I take it from what you've said then that regrettably partly one of the reasons the

evidence hasn't surprised you is because it's consistent with evidence that you've heard in other places about systems of this kind?
A. Yes.

Q. And these are, of course, to some extent systems which are open to these kinds of criticisms in other jurisdictions around Australia, Child Protection's a hard area?
A. Yes, it is.

Q. Was there anything that any of the witnesses said so far this week that told you something you didn't already know, particularly about what's happening in Tasmania?
A. Yes, and in particular Andrea Sturges' evidence yesterday was particularly concerning to me. Now, I have not had the opportunity to follow up the things that she submitted yesterday with senior staff, but I'll be doing that and I'll be doing that in concert with the Secretary of the new Department of Education, Children and Youth because the service is shortly to move there, but there are some big individual issues and there's some big system issues there that she's raised that we really need to deal with.

My alarm, I guess, is that Andrea didn't feel that she could come to me directly with those concerns at any time that I've been Secretary, as you've pointed out, responsible for the portfolio. I would like to think that I'm very approachable when it comes to the system not working, and certainly other witnesses who've appeared, notably Heather Sculthorpe, has always known that she can come to me directly with any concerns and has done so.

Q. Thank you. I wanted to turn to briefly consider some questions about the cohort of children who are in out-of-home care, and I think you've made it plain in your witness statements that you accept that children who have found themselves in the out-of-home care system are inherently vulnerable?
A. Yes.

Q. They're vulnerable for a variety of reasons: firstly, they're vulnerable because of the experiences that they've had that have caused them to come into care?
A. Yes.

Q. Whether that's merely the removal from family which is in itself traumatic, or whether it's because of abuse and neglect in their family of origin?
A. Yes.

Q. So it's clear, would you agree from the evidence that we've heard this week, and perhaps from your own learnings as well, that any system for out-of-home care needs to proceed on an assumption that the children in it will have experienced trauma?
A. Yes.

Q. And will need a response that takes account of that trauma?
A. Yes.

Q. And then, of course, once a child is in the out-of-home care system they're more vulnerable because they're reliant on that system?
A. M'mm.

Q. And you will have heard no doubt in earlier weeks of the Commission some reflections from experts that talk about the fact that one of the reasons kids in out-of-home care are more vulnerable is just because they're in a system and the system itself creates risk?
A. Absolutely.

Q. And children who are living in out-of-home care may not have the same access to family to protect them that children in other systems in the community have?
A. Yes.

Q. And so, the system needs to not only be designed to account for the harm that's already happened to children when they come in, it needs to be a system that is actively designed to prevent further harm?
A. Yes.

Q. And a system that needs to provide an opportunity for children who have been harmed to heal from that harm?
A. Yes.

Q. And so, ultimately would you agree with me that if we were to think in very broad terms about key performance indicators or performance measures for an out-of-home care system, the ultimate measure of a successful system is that

the children thrive in care?
A. Yes.

Q. That their needs are met?
A. Yes.

Q. That they're not exposed to further harm?
A. Yes.

Q. And that if harm does occur, it's responded to and treated in a timely way?
A. Yes.

Q. And so, one of the measures - by no means the only measure - will be to reflect on the extent to which children who have come into the out-of-home care system are able to leave it and lead productive lives as adults in the community?
A. Yeah, that's what we're striving for, yes.

Q. And to be kept away from the kind of path that we heard about from Mr Robinson this morning?
A. Absolutely, yes.

Q. And, in the context of Mr Robinson, you've provided as part of your witness statement some evidence about the overlap or the crossover kids, if I could use that phrase; children who have experienced both out-of-home care and Ashley.

I wonder, Madam Operator, if we could have up on the screen, please, the document that is TDCT.0004.0011.0001. This is one of the attachments that's been provided to the Commission by you, Mr Pervan, and as I understand it, this is a table that shows the number of children in Ashley in a particular given year and the number of those children who, either in that year or in any subsequent year, have been in the out-of-home care system.
A. M'hmm, yes.

Q. And therefore the proportion of children who had been in Ashley who had had as part of their lives, either before or after their time in Ashley, time in out-of-home care?
A. Yes.

Q. And so, of course we can see as we look down at this table that the number of children in Ashley over the years

seems to have fallen quite dramatically; yes?
A. Yes.

Q. I keep having to ask you to say "yes" because a nod won't go on the transcript, Mr Pervan.
A. I'm sorry.

Q. I'm not being a pedant; I just want to make sure we capture your evidence.

So, we can see that the number of children in Ashley has fallen, but the percentage of them coming from out-of-home care has not fallen?
A. Yes.

Q. And so, to the extent that there are systems operating to keep children out of Ashley, those systems don't seem to be keeping the out-of-home care kids out of Ashley; that would be one conclusion to draw from this table?
A. Yes.

Q. Thank you. And could we perhaps - and when we bear in mind that, of course, a very small proportion of Tasmanian kids live in out-of-home care?
A. Yes.

Q. And a very, very small percentage of Tasmanian kids go to Ashley?
A. Yes.

Q. And so, it's quite clear this statistic really brings home what I think we've understood almost as a truism, that children with an out-of-home care background are vastly over-represented in Ashley?
A. Yes. The only qualification I would put on that is that, in any multiple year, say for instance 2017-18 through to 2021, even though they're separated by years, they are often the same children or same young people coming through.

Q. They might be the same kids; I accept that.
A. Which, once again, I would actually say is a failure of the system.

Q. But of course that could be true for kids without an out-of-home care experience as well, couldn't it?
A. Yes.

Q. So there could be kids coming back on both sides of that equation?
A. Yes.

Q. If we could go please, Madam Operator, to the document that's TDCT.0004.0011.0002. This is another table which, as I understand it, Mr Pervan, shows the percentage of children in out-of-home care who have ever had a time in Ashley. And so, what this will show in the left-hand column is the number of children who were in out-of-home care in any given year, and then the number of those children who at any time - not necessarily in that year - have been to Ashley and then a percentage. Yes?
A. Yes.

Q. So obviously down the bottom the number's pretty low because some of those children might still be very young, we don't know the ages of the children in this sample. But if we look for example at the top level, children who were in out-of-home care in 2016 and 2017 who, even if they were newborns, would be old enough to go to Ashley now, we can see that there's 7 per cent of them who have had an Ashley experience. And that would be much higher than the percentage of children in the broader community who would go to Ashley?
A. Yes.

Q. And so again what we can see, looking at it from a different perspective, that if we were to take as one of the measures of the success of the system the keeping of children out of the Youth Justice System, the system's not performing as you would wish it to?
A. Yes.

Q. That can come from the screen. Were you surprise d, Mr Pervan, by Ms Sturges' evidence when she told you of her experience when she worked in the Department of children going into Ashley being recorded in departmental records as leaving care, and then returning to care again when they left Ashley?
A. I have not had enough time to look into Ms Sturges' statement, as I said earlier. Once again, that could be an internal data or record-keeping protocol. I agree that if that is the case, it needs to be changed immediately.

Q. It would certainly be perverse right now when you

consider that you sit over the top of both those structures?
A. Yes.

MS ELLYARD: I will deal with one more topic before the lunch break if I may, Commissioners, but I am moving to a new topic so I can stop now, if you want me to?

PRESIDENT NEAVE: One more topic.

MS ELLYARD: Q. Thank you very much. I wanted to ask you briefly, Mr Pervan, and again, you may be taking some of these on notice because the evidence was given quite recently, about a number of comments about systemic gaps that have emerged in the evidence this week. Firstly, how is it that there are no out-of-home care standards in Tasmania?
A. So, I'll start off from the most positive aspect, which is before the end of this month I'm advised that the draft standards will be issued; that's been the conclusion or is the next step in a process that began with a release of a workbook on out-of-home care standards and carer registration that was released, I believe, in June 2021.

And, it's been a long and far too slow evolution, going back to when I commenced work in 2014, when children would be allocated to a carer, often accompanied with a letter and a notification of payment. And we quickly moved to institute proper agreements with proper conditions, with reporting requirements with oversight in them, and it's evolved over time, as I just said, too slowly.

But now what we've done is develop a set of standards that reflect the National Principles on Child Safe Organisations. So, I agree there are no standards in place at the moment, but shortly there will be. And I'm very pleased that I'm going to see that done before the function moves to Education.

Q. Did you hear the evidence of Ms Brown, and I'll remind media that there's an order that's been made in relation to her name, but you know what I mean when I talk about Ms Brown earlier this week?

She gave some evidence about the absence of out-of-home care standards and expressed the view that the reason there's no out-of-home care standards in Tasmania is

because the government wouldn't be able to meet the standards, recognising that the government has the lion's share of foster care placements.

Do you, as you sit there, have a sense of whether or not those standards that are about to be announced are standards that your carers are going to be able to meet?
A. Yes, and in fact I wouldn't agree that the standards weren't issued because we wouldn't be able to comply; the standards haven't been issued simply because it's taken us this long to actually resource and develop them.

There were other measures in place; they're insufficient, and I'm much happier with the standards. But it is part of a progression of reform that was started before me and will go on after the function moves to Education, Children and Young People because everyone wants children to be safer and everyone wants to do better.

Q. What is it that gives you confidence that all of the 72 per cent of foster carers are going to be able to meet those standards?
A. The process of communication that's been going on with them for quite some time over the need to be compliant with the National Principles; the mapping that's been done against the current regulatory and performance framework to the National Principles; the identification of gaps and action to fill those gaps; as well as the bottom line that, if they don't meet those standards, they won't be carers.

Q. You will no doubt be concerned about the aspect of Ms Sturges' evidence about the transfer from her organisation to Child Safety Services of carers whom she felt were not of good quality and of the different or lower standards, as she would have described it, that seemed to apply to carers for the department? That would have concerned you?
A. It will, and we'll be looking into that.

Q. And so I take it that as you sit there today, you're comfortable that there has been a process that means that carers transitioning into a world where there are standards are going to be already operating in a way that meets them?
A. Yes, and they are already, all of them in any category, subject to Working with Vulnerable People Checks and other measures that give us a level of assurance that children are safe, but that by no means is sufficient, as

I've said now.

MS ELLYARD: Thank you, Mr Pervan.

PRESIDENT NEAVE: Q. I just had one follow up on that. You said draft standards will be issued before the end of this month?
A. Yes.

Q. Does that contemplate a further consultation period? When you said "draft" standards, what are they? Are they the final standards or are they a draft?
A. They are as final as the department is concerned. What we need to do, though, is be mindful of the fact that the legislative framework will be known shortly and we'll need to make sure, once the legislation is passed through Parliament, that the standards map back to the legislation. So, there might be further changes that have to be made after the Parliamentary process on the Child Safe Organisations legislation.

Q. What's the legislative timetable for the introduction of the Child Safe Standards legislation?
A. I'm sorry, I don't have that to the front of my mind, that's the Department of Justice is running with that.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BROMFIELD: Q. Sorry, will you be implementing the draft standards as a draft or will you be waiting for the legislation?
A. I won't be, and I don't want to talk for my colleague. So that will be with the Department of Education, Children and Young People. But we'll be starting to integrate those standards into our contracts and performance requirements. Enforcement will be complicated because there's no statutory base behind enforcing it, only contracts, but with departmental carers, of course, you know, that's a question of performance management.

Q. So, Mr Pervan --
A. We will commence implementation when they're issued, is probably the easiest way of saying it.

Q. Commence implementation when the standards --
A. The standards.

Q. -- when they are issued as finalised standards or as draft standards?
A. They'll be implemented in draft, but they may be subject to change, subject to the legislation.

Q. Okay. So from the - I'm not trying to be pedantic, but we've got other draft standards in attachments and they weren't implemented. So, when they're released at the end of this month, the department will commence implementing them in their current form; they may alter over time?
A. Yes, that's my understanding.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Is that a convenient time to take a break for lunch?

PRESIDENT NEAVE: Yes.

MS ELLYARD: Thank you, Commissioners.

PRESIDENT NEAVE: Thank you, Ms Ellyard.

LUNCHEON ADJOURNMENT

MS ELLYARD: Thank you, Commissioners. Thank you again, Mr Pervan.

Q. Before the lunch break we were talking about standards for out-of-home care and you gave some answers about when they're going to be introduced. Of course, there's already a requirement in the contracts of NGO providers that they comply with the 2011 National Out-of-Home Care Standards; you agree with that?
A. Yes.

Q. And you will have seen from the evidence of the panel of foster care providers yesterday, and indeed from the evidence of Ms Sturges, about the fact that all of those agencies go above and beyond, if I might use that expression, in having been third party accredited to ensure that they're operating in a way that is consistent with standards provided for by the Australian Childhood Foundation?
A. Yes.

Q. And evidence was given about amounts of money spent on

training in child safety and related matters?
A. Yes.

Q. And in relation to resourcing staff, and indeed in the case of Ms Sturges, at least, carers to be able to operate in a trauma-informed and therapeutic way?
A. Yes.

Q. It would be fair to say, wouldn't it, that that's a degree of training and resourcing for carers not presently provided to carers in the department's network?
A. I'm unable to answer that because I don't have any detail beyond the statements of Andrea as to exactly what training they provide compared to exactly what training we provide through the ACF and through our own internal sources, so I'd have to undertake some analysis of the actual data as opposed to what Andrea said versus what other people say.

Q. So, thinking about what you are aware the carers that work directly for the department get, are they all to your knowledge trained in trauma-informed care?
A. My knowledge doesn't extend to the detail of their training. What I would say is that our understanding of the impact of trauma and on how that manifests from early childhood through to adolescence and even into adulthood is still being developed and embedded, and I was hoping to have an opportunity to put some praise on her, and I would like to really credit Sonya Pringle-Jones in particular with bringing her considerable expertise around childhood trauma and its impacts onto people into the conversation when she's advocating for children.

Q. As I understand it, part of the work that Ms Pringle-Jones is doing is certainly creating resources and providing assistance that's going to upskill, if I could use that expression, workers inside the Child Safety System?
A. Absolutely, yes.

Q. Reflecting more broadly, though, about the extent to which carers are resourced and trained to meet the therapeutic and trauma-informed needs of these children, are you able to say with any certainty what the level of training that would have been provided to all of those 72 per cent of carers is?
A. No. I can undertake to get that information for the

Commission, I'm very happy to do that. I would add that, regardless of how much it is, I think we should be doing more.

Q. Because, again, to pick up the thing that you and I agreed on early, the whole things needs to operate in a therapeutic and trauma-informed way?
A. Yes.

Q. And therapeutic and trauma-informed practices aren't things that people are born knowing, they need to learn them?
A. It's an emerging science and I think, as the body of evidence grows, it's something that the entire system needs to learn as the evidence presents.

Q. And to become really part of the foundation or building blocks of anyone's practice if they're going to work successfully in this area?
A. Yes, and particularly at the Care Team level and that's the Care Team as it applies to a children in care or even the Care Teams that might be watching over the progress of a child who's not yet in the care system but might be notified to the ARL. The same would apply across everyone who we would normally have in that Care Team, be they care providers, people from the Intensive Family Engagement Service, school teachers and so on.

Q. One of the ways in which the need to be trauma-informed and perhaps to understand and unpack children's behaviour is relevant to the work of this Commission is in relation to some evidence that you'll have seen that was given by some witnesses about the practice of accepting self-selecting or a concept of considering children able to self-protect, I think you're aware in general terms of that evidence?
A. Yes.

Q. And you've heard that there was evidence from multiple witnesses, including Ms Stokes and Ms Sturges, of their experiences of what they saw was a tolerance in the Child Safety Service for a degree of risk or unrealistic expectations about a child's capacity to self-protect at a young age. Now, assuming for the sake of the moment, of course, that those observations were accurately made and reflected genuine experiences that they'd had, that's obviously very concerning?

A. It is, and in fact, in the process of taking the case to government to have the Lighthouse Initiative funded, which provides young people with a safe place to self-select to, the conversation goes along - and in fact it's been picked up in evidence through the week with the notion of secure welfare or secure facilities; that it's a judgment call of the Care Team in any jurisdiction where this is present, whether you move a child to secure welfare or you let them under watchful eyes self-select to a certain extent.

This is the evidence given, from memory, by Dr Miller. I think she was the first one to use the expression "walking alongside the child" as opposed to taking them to secure welfare which, from my understanding, which is quite limited, is for a very fixed period of time, so 14 to 21 days and then the child has to go back to their normal placement.

And the experience I've been advised of, which is with children who are deeply traumatised or have other issues going on, they might do their time in secure welfare but as soon as they're out they abscond again. So, it's that balance of, do you maintain the therapeutic relationship and the support by walking alongside the child, or do you give them - it's been called, to me it's been called a therapeutic timeout or just a pause by getting them to secure welfare.

And, I appreciate Andrea's very, very passionate observations, but I don't think it's a question as simple as, there's a high tolerance or we let children do what they like. I know personally of a case, and sadly it was publicised in the media here, where one of our Child Safety Officers spent an enormous amount of time building up a rapport with an adolescent, he was 17 at the time; the only connection she could make with him was to provide him with a tent so at least she knew where he was, because he was very good at just avoiding all contact with Crown services. That was reported in the media along the lines that Sonya was talking about this morning and it was sensationalised that we had let that child down by expecting him to live in a tent when he should be in a foster home, et cetera.

The whole backstory behind that about how long it took to get that much trust with him that he would stay in one place for any period of time and we could continue to work

with him was lost in the Parliamentary debates and in the media reporting so --

Q. To interrupt you, Mr Pervan, that's a clear example and thank you for sharing it, of close and careful work by a Child Safety Officer with a child --
A. Yes.

Q. -- to achieve an unorthodox solution, but nevertheless a solution that came through Child Safety involvement.
A. Yes.

Q. The evidence that we've heard this week goes to a slightly different issue which is children either not being able to enter the care system because of referrals to Child Protection not being accepted because of a perception that, oh well, they're 15, they can self-protect, or of a lack of any action of that kind being taken and an acquiescence in such matters as a 14-year-old girl living with a 60-year-old who's plainly got evil intentions towards her. It's a different issue, isn't it?
A. Yes, I get the difference, yes.

Q. Again, to the extent that those observations have been accurately recorded and conveyed to the Commission, they're obviously very concerning?
A. I agree.

Q. Because children who are in out-of-home care are perhaps less able to self-protect than the average child who hasn't gone through the history of trauma and maltreatment that usually accompanies a child in care?
A. Yes.

Q. And so, they're the most in the need of close walking alongside, to pick up your phrase --
A. Yes.

Q. -- and not sending them off in an assumption that, because they've made a choice, their choice should be the one that is given effect?
A. Yes. But I would add to the end of that, there's no general rule or practice there; we'd have to look at them individually case-by-case to see what assumptions were made and why those decisions were taken not to refer or not to intervene.

Q. Thank you for that. So, I take it then that, as far as you're aware, there isn't any directive or general practice that a child, for example once he or she hits 16, is a child who is too old to be taken into the out-of-home care system?
A. No, I'm certainly not aware of any assumption like that.

Q. So there would be no reason why, on the facts of any individual case, a child who presented in a situation of risk and without appropriate accommodation, aged 15 or 16, there'd be no reason in principle why that child couldn't receive an out-of-home care response?
A. In principle, no.

Q. So then, that being the case and that being the practice of your organisation, no doubt it concerns you to hear that some working in the community sector have experienced such a practice?
A. Yes.

Q. Can I turn then briefly to the question of workforce and staffing, and again, I think you say that you heard and accepted the evidence of Ms Lovell and you won't have been surprised by the evidence that other people have given, including Ms Pringle-Jones this morning about observations of workforce pressures in the Child Safety System; substantial unfilled positions?
A. Yep.

Q. And what I understand from Ms Lovell's evidence was, she described a process of it not necessarily being the frontline people who are leaving, but people at the frontline being pointed up the line quite early on and when they're still quite junior to fill practices up the line.
A. Yes.

Q. And so, you've obviously got a retention problem?
A. Yes.

Q. Why?
A. Similar to Child Safety Services nationally: there's multiple reasons for it. The work is incredibly confronting and difficult. I'm personally aware of people who have entered the workforce following achievement of very impressive honours degrees and have left our service within weeks because the academic study of Child Protection

is very much different to the experience of it.

There is that issue of internal progress, but yes, the retention problem is multi-faceted, it goes to not so much work volumes because that varies from place to place and moment to moment, it is more the difficulty of confronting some of these situations and working with some of these families.

I expect that where we are going on the reform journey with the Advice & Referral Line and the Intensive Family Engagement Service and those supports around families, that we have better tools available to Child Safety Officers to de-escalate some of the tensions you get around those families.

Q. But nevertheless, as you said, it's just inherently a very, very difficult job?
A. It's incredibly difficult.

Q. Of its very nature, it involves dealing with families who will be in some degree of crisis?
A. Yes.

Q. And dealing with children who are vulnerable and who may need to be removed against their will and against their family's will from situations of harm?
A. Yes.

Q. And so, whether or not there are surrounding support services and so forth, would you agree with me that a clear theme in the evidence from people like Dr Miller and Ms Sturges this week is the need for the staff doing that work to be extensively supported?
A. Yes.

Q. Including by way of clinical training and clinical supervision?
A. Yes.

Q. They're doing a serious professional job?
A. Yes.

Q. And they require all of the supports that one would expect in that Allied Health social work environment?
A. Yes.

Q. And the evidence seems to be that that's not available at the moment and that the department isn't resourced in a way to support staff doing this difficult work to maintain their practice.
A. So, I would make two observations on the back of that: one is, that is the entire role of the Practice Managers, is to provide that clinical supervision and that's why they're not in a line management position, they don't have designated caseloads and so on.

Also, my observation of Child Safety workers, and it's one of the things that I would like to have had an opportunity to explore, is that, even though we do have a very good employee assistance service that's available to them, they don't access it and I think part of it is - and I've made this observation with respect to one of our regional offices - there is a culture of, sort of, an unnecessary resilience of rights of passages.

Q. Stoicism?
A. Stoicism, this is a really tough job and if you contact the EAP it's because you're not up to the job, and that's completely wrong and, of course, along with the trauma we've been talking about with young people in the system, not enough of our people understand vicarious trauma and don't actually understand that it's not just the tension and the difficulties they're confronting, it's the impact that's actually embedding on them emotionally, and so, yeah, a lot more work needs to be done around supporting the workplace - supporting the workforce's wellbeing, not just their professional capacity.

Q. And I don't want to unduly personalise this, but that's your role, isn't it, to make sure people do understand that, it's the role of you as the head of the organisation to create a culture or to lead a culture that teaches people about vicarious trauma and empowers them to think about their own health and wellbeing?
A. Yes, and we have managed to find the resources to get that - sorry, it's the past tense - we did manage to find the resources to get probably the best workplace health and safety team in the State Government up and running. Certainly, I apologise for smiling, they're some of my favourite people.

When the former Premier announced the department was being disbanded, they were poached within hours; they're

still working with us but they all have - immediately had other jobs to go to because their representations are so good and they work very, very closely with frontline services, particularly those in Child Safety and Ashley around these very issues, and they have deep understanding of it, and I'm just hoping that their agencies that they're going to really appreciate the skills and the asset that - I won't embarrass them by naming them, but what that team have.

Q. Had you observed them to make a difference during the period of time that they were working for you?
A. Yes, particularly at the individual level.

Q. And what kind of measurements, what kind of signs were you using to reach that conclusion that they'd made a difference?
A. Where they have been able to make an impact, where they have been in the workplace, we've had faster returns to work from people who have been on sick leave or, you know, otherwise named as stress leave or workers' compensation, as well as establishing long-term collegial relationships with people to make sure that they continue to feel safe, that they're accessing support and therapy, that they're looking after themselves and so on; they are pretty amazing people.

Q. So is it mainly a program for people who have needed to take time away from work because of workplace stress?
A. No, there's also preventative work in place and I know that the Children, Youth and Families Division have also done a lot of work around the wellbeing of their staff.

COMMISSIONER BROMFIELD: Q. Then why is it that they're not taking the EAP? Is that an historical factor or is that a current factor?
A. It's an historical factor and it's something I also used to observe in the paramedic service; that there's that stoicism as Counsel Assisting referred to it as; that somehow you're weak if you reach out to EAP. It's confidential, so people would only know that you've sought out EAP if you left the workplace during business hours and you said "that's why I'm going", or if you've shared that with a colleague, but I'm aware from feedback, direct feedback from staff, that it's not accessed because it's seen as a lack of toughness, stoicism, to actually do the job and everyone regards the job - and there's a lot of, in

once office in particular, I'm sorry, I'm struggling for the appropriate words, there's a real kind of machismo about it.

Q. And so, are there - is there more to be done here --
A. A lot.

Q. -- in creating this culture?
A. Yes.

Q. Are there initiatives that you're considering?
A. I was. Yes, there are - there's a range of initiatives, and in particular getting wellbeing officers in with our workplace health and safety team who could actually go in and start to chip away at that culture. I mean, it's a culture that's been growing over decades, so undoing it will take some time.

PRESIDENT NEAVE: Q. What about the earlier stage when you're looking to recruit people? Have you got a plan to address the issue of difficulties in recruiting? And how do you go about making sure that you have enough people, and that you ensure from the very beginning that they're adequately trained so they don't react in the way that you've described - helped not to react in that way?
A. Thank you, President. The fact of the matter is that we have - and as I recall Claire did allude to this - we've tried pool recruiting, we've tried strategic recruiting, all sorts of mechanisms and devices within the legislative framework that we've got to recruit better, faster and more of so that we've got a pool of people we can draw on to replace those moving up and out of the system.

They've had some success but not nearly enough, and hence why I think Claire actually did also mention our need to work far closer with UTAS in particular to grow our own, and not just to say this is what we want a graduate to look like, but to ensure that workplace contact and experience is included as part of an undergraduate program in Child Safety or however we bring it up.

Q. What about scholarships for example?
A. Scholarships, I am so old that I can actually remember when governments used to fund what were called cadetships in hard to recruit areas, where people would commit to X years of service in return for the same number of years being funded to go through university. And we have been

exploring that in particular in respect to these areas.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. Can I just ask you about the Practice Manager role, Mr Pervan, because I think what the evidence identifies is two different kinds of support that staff need to do this kind of work: firstly, a support for their wellbeing; and secondly, professional support to resource and sustain their clinical practice. Do you agree with me that's what the evidence shows?
A. Yes.

Q. As I understand it that clinical supervision and support role you see as being played by the Practice Managers; is that right?
A. Yes.

Q. So they're people who don't have a caseload themselves?
A. They will often take on an involvement with cases, and certainly if there's staff turnover they will keep their eyes on, so to speak, to coin a phrase, that person's caseload until it's re-allocated. But they don't have - they don't routinely have cases allocated to them.

If I could just - just a small extension. Yes, they're there for clinical supervision and guidance, but part of that is mentoring and part of the mentoring is about watching your own wellbeing and being careful about how you manage your time, your rest and so on. They're the closest thing we've got to eyes on our staff all the time who can direct them and make sure that they're looking after themselves.

Q. Thank you.

COMMISSIONER BROMFIELD: Q. Can I just ask about those Practice Managers. Do they receive additional training and development and supervision? Is there something that you particularly look for when you're recruiting to those roles to make sure? I mean, these seem to be critical to practice quality, and so you need that special character and the skills that go alongside it?
A. And they're an outcome of the Maria Harries and the redesign work. I'm sorry, I don't have that level of detail to mind but very happy to provide it.

Q. That would be wonderful. We did hear about the principal practitioners in Victoria in that they had to have clinical qualifications, that they also had to have been able to demonstrate that they'd been brave, I think was the phrasing.
A. And part of the more positive aspect of this week has been listening to the interstate experts. It's not something I get enough time to do, so there's a very rich vein of information and ideas that we could tap into that's come out of the Guardians and the interstate reps this week that gives us something to enhance the direction of the design that the system is currently pursuing.

MS ELLYARD: Q. One of the things that Dr Miller spoke about as something that she saw as important and that was a big part of her work when she was the principal practitioner was this idea of leaders leading and the most experienced people being at the frontline rather than back at the office, both because they should do the most difficult work and because that was how they could support and model behaviour; is that a practice in the Child Safety Service in Tasmania? And, if not, would you agree that it's a matter worthy of some consideration?
A. Sorry, it is a practice out of necessity; it is a very lean service, the whole department is very lean, and with the exception of the most senior practitioners, Claire being one of them, and Azra who you've also met, the people at the frontline are the most experienced and I would defer to them in almost every matter for their expertise and their clinical experience.

It is certainly something also around the leadership issue, is that we haven't yet had the opportunity to talk about leadership development, and I'll caveat that by saying, our staff do have access to a number of leadership development programs across government, and we certainly encourage them to engage in and apply for those programs and support them with the time to attend those programs.

But, once again, one of the conversations started with UTAS was around the development of a leadership program within the Child Safety Service because, when you're leading people who are at the front-end of what's often family crises, it's a different sort of leadership to when you're the head of a department.

Q. As I understand the evidence, one of the reasons that might lead to very senior people being on the frontline is because there will be cases that are unallocated and a team leader will be covering that child pending their allocation to a frontline worker; is that right?
A. Yes, the same with the Practice Managers, they will sometimes have their eyes on a case but it's not the same; they maintain surveillance, if you like, on the child on any new notifications, they'll attend court, they'll do all the essentials, but in terms of the face-to-face engagement, that's a CSO or part of a Care Team.

Q. Can I ask you a more general question about the culture within the department, and when I say "the department", I'm conscious that your department covers broader areas than this and I'm asking specifically about child safety and even more particularly, if necessary, about out-of-home care. There's been a number of witnesses give evidence about their observations of what they see as a defensive culture or a culture - they might not have used the word "toxic", but it would describe the kinds of things they've described. There's a statement from Dr Brewer about her experiences in the department and various other people have reflected on their observations that it's difficult inside the department, and I think you will have heard Ms Pringle-Jones's observations this morning about - with some reasons given for why life inside the department's difficult, and I wonder, do you recognise those descriptions of the service that we've heard evidence about?
A. Yes, I do, and I have been observing a change over the last few years.

There's a maxim in Health that comes from the Institute of Health Innovation in Massachusetts, which is, "Every system is perfectly designed to get the results it gets". So, if the results are bad, if they're toxic, if there's vicarious trauma, that's because the system's designed to get that. So, part of what drove the redesign, the creation of the ARL and so on and so forth, was because we recognised that just throwing additional resources at the system as it was would just replicate the results it was getting, and that doesn't just mean about the number of children in care and their experiences in care, it was the experience of everyone involved in the system.

And in particular the difference that the ARL has made

and the services that it co-ordinates around the IFES and so on has started to crack that siege culture of, you know, this is a fight, we're in a battle to protect these kids. In some cases it's the kind of, we're saving these children or we're protecting these children from harm, when in fact what it might have needed, as with the witness this morning, was someone to recognise the mental health and social issues that were occurring in that family and to support them.

I'd like to think that, if he came to light now, his experience of our system would be entirely different; he would still be with his family, he wouldn't have gone into the choices that he made or fell into and ended up where he was this morning when he gave evidence.

Q. And we would all wish that, but if one listened to the evidence of people like Mr Davenport who worked in Child Safety Services until recently one wouldn't feel confident, would one, because he gave evidence of what he called values questions that he observed amongst his colleagues that might suggest the lingering of those kinds of attitudes that won't get good outcomes for children.
A. I agree, and actually while I have the opportunity I'd also like to acknowledge Jack's courage for sharing his own childhood abuse experience so openly, but in terms of the evidence he gave, we're talking about cultural change of an organisation that's been around in one form or another for 100 years.

I recently went and visited an employee at St John's Park who left the Child Safety Service after 50 years, and she started off as a stenographer with the Director of Child Safety 50 years ago, and that was the Child Safety function in Tasmania; it was one person and police, and the one person used to just deliver kids around.

So that, the culture that grew and which was reflected by the witness statements this week is under a process of change but it's going to take consistency and it's going to require sticking with this reform direction in all of its aspects and all of its learnings, including the impacts of trauma, long enough to witness that change and not have another change and another new direction and, you know, a different internal structure, but they're moving to a new agency where a lot of those things are really well understood and the safeguarding function is already well

ahead in its thinking about how you move that culture.

Q. Thank you, and I think we'll come back to some of that later, if I may. Just to finish off this question of culture. In your answer to the request for statement 18 you gave us some details from the results of the staff surveys that were conducted and as in the organisation you've only had a couple and you've made some points about the relatively small sample size of the responders to the staff survey, but with those provisos acknowledged, no doubt you would have been concerned by some of the results, particularly in the area of whether or not staff felt that significant change was well managed?
A. Yes.

Q. Only 26 per cent of people thought that it was?
A. (Witness nods.)

Q. And of course that's across your whole department, but presumably at least in part must be taken as a bit of a judgment on the way the kind of changes that are happening in Child Safety Services are being managed?
A. Yep, and they were certainly very strong messages that we received, and had we continued as an organisation there would have been a lot of reflection around, first of all, our ability to drill down into that data and see whether that response was coming from within Children, Youth and Families, or from Housing or from the Family Violence Unit and so on, and to really get a better understanding of, if this is the result from that area, what do they think good looks like? Is good a matter of more information, because the most frequent complaint I get is from too much information that they don't - many staff don't see as particularly relevant to their working day coming through, or is it engagement? Do they want to be part of the design of that change, which is of course how the redesign was undertaken, it wasn't using external consultants, it was the staff working with Professor Harries around what a good service would look like, and in fact very similar to what Sonya was indicating today would be one of the alternative ways forward.

Q. A couple of the other results that I noted was, firstly, 55 per cent of people agreed with the proposition that senior management modelled the values of the organisation. As the head of the organisation, no doubt that concerned you?

A. Yes.

Q. And also, perhaps relevantly for some of the evidence and background information we've received, only 45 per cent felt confident that they would be protected from reprisals?
A. I know, this --

Q. And can I saw to you, Mr Pervan, and perhaps it's not a surprise to you, that the Commission's been told repeatedly, sometimes in witness statements and sometimes in other information, of concerns that people in this sector have about the consequences for them or for their organisation if they criticise the department. Now, that must worry you?
A. It does, and I'm aware that similar responses came in the Health system after the review of the coronavirus outbreak in the north-west.

I am not across data from similar jurisdictions as to whether this is a thing that's common outside Tasmania, but the concept of reprisals, apart from being unlawful, is something that I've not been witness to and, as I said earlier in evidence around Andrea Sturges and others, I've never declined a request for a discussion or a meeting or rebuked someone in an email or done anything like it, and I encourage all of the staff on the executive to be the same way, that the organisation's only going to go forward and actually deliver on its core values and its functions if we are open to hearing information from the frontline in particular and responding to it positively and engaging with people.

Q. Mr Pervan, I accept what you say, that that's what you consider to be the attitude of you and your department, but you'd accept, wouldn't you, that there's at least a communication issue with getting that message out for there to be the level of concern inside your department and in the sector about the consequences of speaking up?
A. Yes. Yes, I agree.

Q. And communication issues have at their core an obligation on the part of the person sending the message to send it well?
A. Yes.

Q. So again, not to personalise it, but it's your problem, isn't it, to solve --

A. Yes.

Q. -- the apprehension that it appears some people have?
A. Yes, and when - the organisation values were set in concert with the staff; they drove them, they drafted them and we have implemented them, and we've tried to influence that culture by a program of staff nominating each other for demonstrating those values so that people can see what that look likes in practice and we've done it across the organisation.

Once again, cultural change is something that takes a very long time, but it requires consistency over a long period of time, not, okay we're going to park the values work for one minute because we've got to respond to crisis X, or we're going to park the values because now we have got to run quarantine hotels.

And in fact the quarantine program, totally different to out-of-home care, I get it, but in terms of the organisation that I'm responsible for, was a model in terms of how it was managed, how the values were demonstrated and how it delivered an extraordinary result because it was values-driven.

Q. But just to close off on this point of a culture that welcomes critical feedback and makes it clear to all involved that you'd welcome and would join in the feedback, your reflection earlier on today that you were disappointed that Ms Sturges didn't come forward to you, I mean, we need to take that as you're disappointed that the system that you department has established wasn't a system that gave her confidence that she could come forward to you?
A. Well, my disappointment's at two levels: one, yes, that there's not a systemic process where she could raise those issues forward and that we could use them as part of a continuous improvement process, and disappointed personally, because I know Andrea, and she worked while I was Acting Secretary with the department for a couple of years, that she didn't feel she could just email or pick up the phone or ask me for a coffee, formally represent those concerns to me.

Q. And that's something presumably you've reflected on?
A. Yes.

Q. That why the system that you lead didn't create that

sense of safety for her?
A. Yes.

Q. Thank you. A very quick point on foster carers. You'll have seen that there was a number of pieces of evidence about the adversarial relationship between Child Safety Officers and foster carers, and that's an observation that was made by a few different people?
A. I heard, yes.

Q. And I take it, that wouldn't have been new to you, that evidence?
A. No.

Q. You also would have heard, and I think you've said in your own witness statement, that there's a shortage of foster carers and one of the pinch points in the system is that there's not a huge range of people to whom children can be sent to be safely placed?
A. Yes.

Q. The Commission's heard some evidence that the department's stopped recruiting foster carers at the moment, is that right?
A. I'll have to pursue that one, I'm not sure that is right but I'll have to look into that after I heard it yesterday.

Q. I think that was part of the evidence that Dr Watchorn I think gave.
A. Yes.

Q. And that would seem odd, if there's a shortage, to not be recruiting for new ones?
A. It would seem odd, but we would be equally encouraging - well, the carers that were here in the panel yesterday to be expanding their recruitment as well.

Q. And that would, presumably longer term, mean a shift in the proportion of care provided directly through the department and care provided through NGOs?

COMMISSIONER BROMFIELD: Q. Is that an intention?
A. I'm not sure whether it's an intention; I think it's more a question of, we're recognising where the expertise is.

Q. Sorry, I don't quite understand that answer. Is there any intention or evolution at the moment of transitioning out-of-home care from the state to the non-government sector?
A. I think, as part of the redesign, there's an intention to move to purchaser-provider, but as we've heard before, that will require - (a) it will require a specific policy decision by government, and then it will require proper legislation and resourcing. At the moment we're not set up to do it well.

Q. And, in that context, with no kind of imminent transfer, it does seem odd if there's no active recruitment.
A. As I said, I'll have to look into that and provide a written response. I'm not aware of a decision to actively not recruit.

COMMISSIONER BENJAMIN: Q. That would be something you would be aware of though, wouldn't it, if it was there?
A. No. No, that's delegated through to the division. I wouldn't - that wouldn't come across my desk or be reported to me in any way.

Q. That's a fairly significant policy decision though, isn't it?
A. As I said, I don't think a policy decision's been made yet, that's why I need to look into the detail and come back to the Commission with that detail.

Q. So it's possible that a policy's been changed but that you - or a possible policy change has been implemented but you don't know about it at this stage?
A. The policy hasn't changed and, as I said, I don't know that we're not actively recruiting, so I need to go back and get the detail of that.

PRESIDENT NEAVE: Q. I think you said that there was an intention to move to the purchaser-provider model?
A. Yes, but there's no agreed plan, timing or approval to do so.

Q. It would have to be something that you would support, would you not?
A. As part of the strategy over time, yes. A significant decision, it would be.

MS ELLYARD: Q. I want to turn now to ask you some questions that arise and we're going to get onto the Care Concern process and then the case studies, Mr Pervan, but firstly, did you have the opportunity to familiarise yourself, perhaps at the time or since, with any of the evidence from the first week of the hearing? And in particular there was some evidence from Professor Palmer from California on questions of organisational culture and learnings that might be brought to bear in an analysis of achieving cultural change?
A. Yes.

Q. One of the things he talked about in his evidence was this concept of high reliability organisations; organisations where the cost of error or the risk of error is high and the care that such organisations take to monitor near misses and to scrutinise their processes. And he gave the example of a hospital setting, which would be well familiar to you. It's very common, isn't it, in a hospital setting for there to be reviews after near misses or very careful control over the different parts of a hospital process?
A. Yes.

Q. And that's because failures in a hospital process, whether it's the connection of the wrong gas or the wrong medicine or anything like that, can be catastrophic?
A. Yes.

Q. And of course we know very clearly that the risks of child sexual abuse can also, if they manifest, cause very difficult harm?
A. (Witness nods.)

Q. And so, the Child Protection System, Professor Palmer suggested, and I take it you would agree, is a system that could potentially benefit from quite structured reflection on past cases and learnings from errors or near misses of the past?
A. Absolutely.

Q. And you'll have heard me perhaps mention in my opening and no doubt you're aware, although it's before your time in the department, of what I've described as a notorious case of child sexual exploitation which occurred in Tasmania over a decade ago now?
A. Yes.

Q. And you'll be familiar with the fact that there were a range of reviews at the time, both internal to the department and external, that sought to understand where the systems had let that young person down and to build a better system?
A. Yes.

Q. I'm going to ask that we have brought up, please, Madam Operator, CCYP.0001.0007.0927_PA. Just to orient you first with the first page of this document, Mr Pervan. This is a document reflective of an internal review done by Child Protection, as it was then known, into this case prior to the matter going to the Children's Commissioner for an extensive review. You may not have seen this document, but that's what it is.
A. Thank you.

Q. I'm showing you the front page and then going through to the third page?
A. Sorry, the medication I've just taken, I can't read that screen, sorry.

Q. I'm sorry, can we move you closer to the screen and we'll also make sure we zoom it up as well.
A. Thank you.

Q. I'll just pause for a moment in case your movement has lost the image of you on the screen, Mr Pervan. May we continue? Thank you.

COMMISSIONER BROMFIELD: Q. Sorry, can you see it now?
A. I'm having a lot of difficulties but I can see, yes.

MS ELLYARD: Would it be convenient if we stood down for a brief time, Mr Pervan, and we could resume in a couple of minutes?
A. No. I'm okay to proceed.

Q. Please do let me know if you need a break but if you're content to continue. We'll just scroll up to the top of the document, Madam Operator, if we may just so Mr Pervan can see the heading of the document, "Child Protection internal review report May 2010". If we go then over to page 2 just to orient Mr Pervan in page 2. It's clear that this is an internal review report that made findings and makes recommendations?

A. Yes.

Q. I will then go through to the next page, please, because the part of the document that I want to draw your attention to is the page that says, "Major findings". I don't want to go to the facts of the case in any detail, Mr Pervan, but I don't think I'm being unfair to you in assuming that you know the background circumstances of this case. Is that right?
A. No, I do not. Is this the case that you were talking about earlier?

Q. Yes.
A. Yes, I do.

Q. Thank you. So, I'm drawing your attention to some of the findings that were made inside the department as a result of that case. Firstly, I'm drawing your attention to paragraph 3. There was a finding at that time in May 2010 that, in the context of the Child Protection officers who worked with that family, there was an immature understanding of risk and an absence of proper risk assessment. That was one of the findings that was made?

Going down to paragraph 6. There was a finding in that particular case of an inappropriate referral with the provision of misleading information to the agency to whom the referral was being made. You see that?
A. Yes.

Q. Then, in paragraph 7, the finding of the review was that there was an acceptance of or ignorance of, or apathy towards sexual abuse and sexual activity by Child Protection.
A. Yes.

Q. And that Child Protection was passive or erratic in their responses to those reports of abuse?
A. Yes.

Q. Secondly, drawing your attention to paragraph 8, most of that paragraph's about the attitude of police, but at the end in the final sentence it appears that there was a finding that at a certain point in time during the period of time this child was being exploited, there was a discussion of perhaps whether the child was consenting to the exploitation?

A. Yes.

Q. Then over the page, Madam Operator, to paragraph 12. There was a finding that in that case there had been no internal checks and balances to make sure that the case was considered overall, and that there had been an undermining of the group that existed to consider whether or not court applications should be made?
A. Yep.

Q. Then, paragraph 13, there was a finding that at the time there was a backlog which had led to a period of the family being unallocated and not having a worker: yes?
A. Yes.

Q. Finally in 14 there was a finding that the files were incomplete or that there was information that might be inaccurate, so that it was challenging to understand the whole course of the children's experience.
A. (Witness nods.)

Q. This is before your time, but this we can understand to be a review undertaken at a point of time following an extremely serious example of harm caused to a child in the care of the department?
A. Yes.

Q. Thank you, Madam Operator, that can come from the screen. What we understand is that the Care Concern process, which as I understand from your evidence is on its way to being replaced, came in in 2013 in the light of, although not necessarily directly because of, findings that occurred about the extent to which risks, including risk of sexual harm, were being well managed within the department. Is that right?
A. Yes.

Q. And so you say in your statement that the Care Concern process is going to be replaced soon by a wellbeing in care process?
A. Yes.

Q. What's the relevance of the change? Is it just the terminology or is it something more substantial?
A. It's something more substantial and it was discussed this morning around the six domains of wellbeing. It's to --

Q. Perhaps I'll ask it a different way. Is it expected that it will expand or narrow the range of matters that get investigated?
A. To expand significantly, in that, wellbeing is more than an absence of abuse, and so, the intent of it is to actually look at every domain of the child's life in an effort to make sure that they do feel loved and safe, that they are receiving education, that they are thriving.

Up until now whether a child has or fails to thrive hasn't been something that we've been able to monitor, to track, to support, because instead we've just looked at more of a compliance approach; you know, the absence of threat, the absence of abuse and the absence of harm, and a child's life should be so much bigger than that.

And, as you pointed out, as the parent, the state has an obligation to make sure that the broadest possible assessment and monitoring is put in place around our children.

Q. At the moment, as I understand it, the Care Concern process is still the program that's in place?
A. Yes.

Q. So, if, for example, God forbid, a notification was made today about a child being at risk of sexual harm in a placement, it's the Care Concern process that would respond?
A. Yes.

Q. And so, whilst recognising that changes are afoot I do want to understand how something might go through the system were a notification to be made.

At paragraph 227, if you want to go to it, Mr Pervan, in your statement in response to RFS-23, you talk about the Responding to Care Concerns process, and you attach a document which I'll ask to come up on the screen, please, it's TRFS.0023.0048.0062. This is one of the many attachments to your statements, Mr Pervan, and I take it you can recognise it on its face as a document generated by the Department of Health and Human Services as it then was?
A. Yes.

Q. And this is the Care Concerns process from February

2013 which is still the process in place?
A. Yes.

Q. And what we can see if we zoom in, please, Madam Operator on the first paragraph of the summary, the context of the document is the existence of a legislative responsibility resting on the Secretary to ensure that children in out-of-home care receive a level of care consistent with the principles in the Act?
A. Yes.

Q. And part of that is the need for a process that will appropriately investigate any concern that a child's been abused or neglected or is not receiving appropriate quality of care?
A. Yes.

Q. What's made clear, if we look to the third paragraph under that same heading, please, Madam Operator, if we could just zoom in a little bit further down - sorry, not to the next page yet, just that third paragraph that begins, "There is a broad range of issues", do you see that Mr Pervan?
A. Yes.

Q. What that reflects is that there are two pathways under the Care Concerns process, two ways in which a concern that's raised can be investigated: one relates to quality of care concerns and one relates to serious abuse and neglect of a child in out-of-home care?
A. Yes.

Q. And so, at the moment matters can be categorised and then investigated in accordance with their categorisation?
A. Yes.

Q. And the investigation process is different depending on which pathway you take?
A. Yes.

Q. If we could go now please, Madam Operator, to the policy statement and to the third paragraph under the policy statement. The policy as it exists at the moment notes that concerns relating to the provision of care can vary very widely, from minor quality issues through to serious neglect, and so, there's two different schedules of practice that can be used?

A. Yes.

Q. If we go over, please, Madam Operator, to page 4, we see the definitions for the two different kinds of abuse that will lead to matters going down one or other of the pathways. So, allegations of severe abuse and neglect, you see just there where the pointer is?
A. Yes.

Q. There's four dot points which summarise the kinds of matters that will be categorised as allegations of severe abuse and neglect, and they relevantly include for our purposes, allegations of sexual abuse: yes?
A. Yes.

Q. A bit further down, Madam Operator, there's a sentence that says, "Quality of Care Concerns are defined as", then there's a long list of matters which fall into the category of quality of Care Concerns?
A. Yes.

Q. It would appear, consistent with the document as we've just looked at, that any allegation of potential sexual abuse of a child would always be a severe abuse and neglect investigation?
A. Yes.

Q. Any allegation that a child's at risk of sexual exploitation, would you say that would always be a serious abuse and neglect?
A. Yes.

Q. What about whether or not a child is being harmed by or indeed themselves engaging in harmful sexual behaviours; where would you see that kind of matter sitting, if at all, in this policy?
A. I would say that was captured under "inappropriate management of child sexualised behaviours", as a quality of Care Concern.

Q. Thank you. And just to follow that through, that would mean that, depending of course on the circumstances of the individual case, an allegation that a child in care was being sexually harmed by another child in care wouldn't be a serious abuse and neglect investigation?

A. Without knowing the details, the circumstances, and

without being a Child Safety practitioner, I would have thought it would be a serious issue for investigation.

Q. So, it might depend on the individual circumstances, but clearly on the face of the way this current system categorises things, harmful sexual behaviours in placement pose a challenge to easy categorisation; can we agree on that?
A. Yes.

Q. Thank you. Can I ask, please, Madam Operator, that we have TRFS.0023.0048.0034, which is Schedule 2, that is the practice guide for then examining or pursuing an investigation into a serious abuse and neglect concern.

One of the things that you say in your statement in response to RFS-21, and it's a quote from this policy, is that:

Staff independent of the child's care and case management will investigate a serious abuse and neglect concern.

So, it's not something that will be done by the child's case manager; is that right?
A. The child's case manager would be involved, but the investigation would be undertaken by someone independent.

Q. So, they'll consult no doubt?
A. Yes.

Q. But they won't be the responsible decision-maker?
A. No.

Q. If we go, please, to page 4, Madam Operator, we see a description of the process that's going to be followed. If we start at page 3, thank you very much, and then at the very top of the page we see that, the first thing that's going to happen is that there will be, once a care concern's received, there is to be a review meeting with various people involved.

And then, down the bottom of that section just above the heading, "Coordination meeting", if the nature of concern relates to acute or severe physical abuse, sexual abuse or neglect, the matter should be referred to the Quality Improvement and Workforce Development Team, and the

referral will be via a formal referral to the SQPA, the Senior Quality and Practice Advisor?
A. Yes.

Q. Now, as I understand your evidence there isn't at the moment, because the position's been abolished, a Senior Quality and Practice Advisor; is that right?
A. That's correct.

Q. And there isn't at the moment, because it's been abolished, a Quality Improvement and Workforce Development Team?
A. That's correct.

Q. So I'm sure you can anticipate my question. God forbid an allegation comes in today, who's going to conduct the Care Concern review?
A. Depending on the detail of the case, my assumption from not a sexual abuse allegation or care concern but another matter, is that it would go to the Executive Director, and Ms Lovell would determine who was best placed to undertake the investigation. And once again --

Q. Who does she have to choose from? You said she'll decide who's best placed?
A. She may often do it herself, depending on the complexity and the severity of the issue. She might also use a team leader or a peer from another region; it depends on, as I said, the complexities of the case.

Can I just - there's just one other thing. And depending on, if it's a care concern relating to a child that's currently in care or if - for example, if the case studies were reported as an historic event, then we would more than likely convene the Serious Event Review team and get a multi-agency approach to review. As you pointed out, in the Health system, you'd get multiple disciplines around the table to review the entire event, the circumstances, all the evidence, to work out where the system failed such that this terrible outcome could occur.

Q. We've had reports of the demise of the Serious Events Review team, but I gather those reports were inaccurate?
A. Yes. So, the Serious Event Review team was established originally to support a particular coronial inquiry and it was a standing resource for a considerable period of time, because there was a large number of cases

and they were quite detailed and the Coroner's requirements for the level and depth of the investigation were substantial. When that particular matter was resolved, then the team went back to their regular duties, but we have subsequently convened the team and that process for reviewing a matter at Ashley, for instance --

Q. Indeed.
A. -- and other issues. So the team, the mechanism is brought together as required and it's still there and those people still have the expertise to undertake the investigations.

Q. Has it been convened in the recent past since, for example, the disbanding of the other mechanisms like the --
A. For a review at Ashley, yes.

Q. But not for reviewing in the out-of-home care context?
A. Not that I'm aware of but I'm happy to check that with the division.

Q. Thank you for that. Can I just ask you about the potential scope of application of these policies. As I understand it, although these are expressed as being policies to investigate concerns about a child in care, I understand in part from the evidence of Ms Lovell that the focus of these is where the risks posed to the child arises from the carer, so the concern is that it's the carer that's harming the child; is that right?
A. Well, in general I think that would be correct, but my observation is, the same or similar process would apply if it was between two children in the household. We have zero tolerance for sexual abuse regardless of the parties involved.

Q. So, there ought to be a way to use this mechanism, for example, to pick up your example, investigate in a proper and independent way allegations that one child has displayed harmful sexual behaviours towards another child in a home?
A. Yes.

Q. What about a child who's in a residential or a Salaried Care placement who's at risk of sexual exploitation; does this Care Concern policy respond to that, where the risk isn't coming from anyone in the service system but from someone outside the service system?

A. I would assume that it would; our capacity to intervene, however, is somewhat different. If the purpose of the investigation is to work out if the child is at risk and what we can do to mitigate or entirely remove that risk, and we're dealing in this case with an adolescent who's subject to child exploitation by someone outside our control, then all we can do is liaise with police to see what we can do there; we can try and counsel the young person, there are things that we can do, but the outcome isn't the same as the investigation of sexual abuse of a child in an out-of-home care placement by someone in that household.

Q. What about if the care concern arises from the alleged conduct of a Child Safety employee; an allegation, for example, of grooming and boundary violation behaviours that are placing the child at risk of harm? Does this policy respond in those circumstances?
A. It does, but in that instance there would be an immediate organisational response around Employment Direction 5 and 4.

Q. But it's a care concern?
A. It is a care concern.

Q. But there are other levers to pull as well, because they're an employee?
A. Yes, and our concern will be the risks that the child is exposed to but there would be the Care Concern investigation which focuses on the child and their safety, and then there would be the employment investigation under ED5.

Q. That can come from the screen, thank you, Madam Operator. I think you were here during the evidence of the Children's Commissioner earlier today?
A. I was, yes.

Q. You'll have heard me ask her about a part of the policy document that we've already looked at which referred to the existence of a Care Concern Monitoring Group?
A. Yes.

Q. Of which she was a member but to which she's never been invited. That group also seems to depend on the existence of bodies and people who don't exist anymore, including the Quality Improvement and Workforce Development

Group. At the moment what is the monitoring arrangement for care concerns?
A. I would have to consult with the acting Deputy Secretary and with the Executive Director to be able to answer your question, because that's a matter internal to CYF, and I think it's not a deliberate act to not convene the committee, there is monitoring, because I'm aware that Claire keeps a careful eye on care concerns being reported around children in care. But, as I said, I would have to consult with them to see what mechanism and the regularity of the reporting, or if it's on an incident basis.

Q. On the question of monitoring by the Children's Commissioner, I accept that she said that she receives data, but you'll recall she said that she doesn't find out what category of care concern the matter fell into or what the issues were, so her monitoring won't be of a kind to, for example, identify whether the correct pathway was chosen, where the matters were minimised, or whether the outcome was sufficient. And, as I read the policy, it seems that this Care Concern Monitoring Group would have been previously intended to conduct that function?
A. That seems to be the intent of the document, yes.

Q. And it's an important function, you would agree?
A. Yes.

Q. In the absence of any other external body with the power to look at the detail of the decisions that get made?
A. I'm not certain that that's true.

Q. Who is it that can review the detail of these Care Concern processes?
A. I think the Ombudsman is able to look into the detail of any administrative decision.

Q. So, if someone exercised their right to go and approach the Ombudsman, the Ombudsman, you would say, could look into it?
A. We've had previous approaches from the Ombudsman. If an individual thought that the decision or the conduct of our officers was a breach of the Code of Conduct or otherwise corrupt, they could also go to the Integrity Commission.

Q. It feels like both of those processes would not quite get to the point which is the need for appropriate

monitoring of whether child-focused outcomes to secure safety are being achieved. Do you accept that?
A. Yes.

Q. And when one looks at what was going to be the membership of the monitoring group, community sector organisations, CREATE, the Foster Care Association and the Children's Commissioner, one can clearly see the kind of expert analysis that that monitoring group might have been intended to provide?
A. I would have said "broad-based analysis", and that's also good.

Q. Yes, people with expertise in the sector?
A. Yes.

Q. And so it seems, Mr Pervan, that this is an example of - I don't want to use the word "piecemeal" in a pejorative way, but what seems to have happened is there's been leadership changes in the department that have resulted in the absence of people who, I think we can agree, were going to be performing a key function in monitoring and responding to serious care concerns, and it appears that those positions have been abolished without any overt thought being given to these policies needing to be updated and new people being put in to do that work. Do you accept that?
A. I'm not able to, simply because I don't know what was in people's minds when those jobs were abolished and what they thought would replace those policies. There may well be alternative systems in place, I'm just not aware of them.

Q. We asked you to tell us about the Care Concerns process and these are the documents you gave us?
A. Yes.

Q. Which suggests that at the very least if people did turn their mind to new arrangements they haven't documented them because, if they had, you would have given us those documents?
A. Yes.

PRESIDENT NEAVE: Q. I'll just ask a simple question. Somehow or other a complaint is made that suggests that a child is being subjected to continuing abuse, sexual abuse in the system.

A. Yes.

Q. How does the department respond to that quickly, to protect that child from further abuse? Is it through this process? Is it through the monitoring process?
A. Ultimately, it is through the Care Concern process, but that would follow - a report's made to the Advice & Referral Line along those lines, there would be an immediate upgrade or escalation of the issue to the Child Safety Service, and as soon as possible and certainly within 24 hours the police and the Child Safety Service would investigate, on site. It's one thing that we do do extremely well.

MS ELLYARD: With the Commission's leave I'm going to turn to ask Mr Pervan briefly about a couple of the case studies. We won't get through them all before we need to take a break.

COMMISSIONER BROMFIELD: Can I, just before you do.

Q. It's a question on notice, Mr Pervan, because I'm not confident that the Care Concern process, as you explained it today, is consistent with the way Ms Lovell explained it to us on Monday, where there was, I think a lot more confusion about what would happen in the case of, for example, harmful sexual behaviours, and I certainly came away with the impression that it was being applied to matters involving concerns about either omission or commission by carers solely. And I'd just like to get some confirmation, so that at the end of these hearings I actually do understand the Care Concern process.
A. I'm very happy to get that advice from the division.

MS ELLYARD: Thank you, Commissioner Bromfield.

Q. Can I invite you, Mr Pervan, to turn to the case studies, and we'll look briefly at at least one of them before we take a break. Now, just so that we're all on the same page, as you'll have seen, Mr Pervan, these are case studies that are based on real cases which were included in a list provided by your department to the Commission of children where there had been an allegation recorded of them having experienced child sexual abuse?
A. Yes.

Q. And in each of these four case studies you will have

had your attention drawn to the existence of documents from the case file that substantiate or speak to the summaries that we've been given, but for the protection of these children they've been de-identified and for their further protection we're not going to talk in detail about the facts here today.

But if we look firstly to the case study of Edith, Edith's case study shows, if you would accept this as a summary, two separate opportunities afforded to Child Safety Services, the first one when a service provider spoke to Child Safety Services and the second time when a notification was made by Edith's parent; two separate chances for there to be an investigation into whether or not there was anything untoward happening to Edith. And, it would appear from the file that neither of those opportunities were taken up by Child Safety Services; would you accept that?
A. I accept that there's no record of anything having been followed up on, yes.

Q. And perhaps this goes to the question of records, but following up something of that seriousness would ordinarily be something that your staff would take a note of?
A. I would hope so.

Q. Yes. And so, whilst we can't be completely sure, it's open to draw the inference that nothing of substance was done because nothing's documented as having been done?
A. That's inferred by the written record, yes.

Q. Yes, thank you. What we then see is that tragically, Edith had the experience of being returned home and being seriously sexual abused by persons who were living in that home so that she then had to come back into care. And it appears that there was a further notification of sexualised behaviour with no clear response, and that there was at least one whole year when this child wasn't seen at all by Child Safety Services. I'm looking at paragraph 10, if you want to check.
A. Yes.

Q. And then what we see is, tragically, she had another experience of being abused, and it turns out that in the foster placement in which she'd been placed after her removal from her parent, she'd been abused again and the conclusion was that she had indeed been abused, although

police prosecution wasn't possible.

So, with that very broad summary, can I ask you a very open question: when you look at this, what do you see didn't happen that should have happened?
A. In the first instance, what I'd like to say is that this is a catastrophic outcome and no-one would defend the actions of the department as they're represented here. I don't know from this scenario the experience, the seniority of the officers involved, what decisions they did make, why they made them and so on. So there's some contextual information that don't lessen the terrible outcome that this poor woman, or poor young woman, has experienced. And, once again, this is the sort of thing that would be referred to the Serious Event Review team, and that may result in disciplinary action and more so, but that's after the event.

Q. Yes, indeed.
A. And what we would prefer is if there were sufficient eyes on Edith such that, in these initial times, expert advice was sought; were the behaviours, you know, within a normal range of a person of that age. Encouraging the service provider who has reported to keep reporting anything that they find anything is what they regard as abnormal or unusual, to work with the foster placement around what kind of behavioural supports might be necessary or what kind of signals they should watch for if they think that Edith is at risk, and then of course once there's a possibility of abuse, as I said before, we have a zero tolerance for that, and that should be immediately escalated and the police involved initially. I don't know why that did not happen in this case, but it does require a much more serious and in-depth review.

Q. It certainly seems that the behaviours and the observations weren't received by Child Safety Services as being concerning. Their hackles - they didn't read the red flags that perhaps we can look now and see, red flags about behaviours, red flags about matters of that kind?
A. Yes. I'm sorry to talk about old experiences, but in Western Australia while I was in the Department of Health I supported the Department of Communities there with two investigations not dissimilar to this sort of scenario, and what it came down to, with the assistance of Professor Harries and a former Head of Agency, Jane Brasier from the Department of Communities, was in both cases the outcomes

were similar; both terrible outcomes.

In one, there was a failure of decision making and a failure to comply with practice standards and a risk assessment system like Signs of Safety that we use now, and that resulted in disciplinary action against two departmental staff.

In the other, they did intervene, they interviewed, they followed all of the risk frameworks; they did everything that was expected of them to keep that child safe, and tragically, it resulted in further abuse and a not dissimilar outcome.

But sadly in the system, as it presents, not every intervention works, not every risk management framework works, and in the worst case scenario, these sorts of things do happen, but that's why you need a very robust and potentially independent review process to make sure that people have complied with the policies and the risk frameworks that are in place and have done everything they can to keep the child safe.

Q. Thank you.

COMMISSIONER BROMFIELD: Q. Sorry, can I follow up on that? With respect, what decade was it that those cases were heard in Western Australia?
A. Western Australia, that would have been 1994 in both of them.

Q. And in this example with Edith, she came into care, under 5, in the mid-2000s.
A. Yes.

Q. Do you think it's reasonable to expect that we would have gotten better at handling and identifying child sexual abuse in the last three decades?
A. Absolutely.

Q. Does it distress you that that doesn't appear to be the case here?
A. Yes, deeply.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Q. Can I ask you whether it also

indicates that there may be some issues about data in the department? In this, there's no record of how things were followed up, no record of anything being done. Now, maybe nothing was done; perhaps something was, but we wouldn't know from --
A. Absolutely, I agree.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: It's convenient to take a break, Commissioners.

PRESIDENT NEAVE: Thank you.

SHORT ADJOURNMENT

MS ELLYARD: Thank you, Commissioners. Thank you, Mr Pervan. Just to flag, Commissioners, we are going to continue with Mr Pervan's evidence until no later than 3.30 because he has another obligation.

Q. Mr Pervan, can I take you briefly to the case study of Linda, and that's a case study which involves a young person who clearly had an extensive trauma history and, as the facts of the case reveal, more than one serious attempt at self-harm; do you agree?
A. Yes.

Q. And she found herself placed in residential care in the context of her being at risk of sexual exploitation; yes?
A. Yes.

Q. And as the facts reveal, it appears that being placed in residential care didn't keep her safe from continued exploitation, and it was revealed on more than one occasion that she was being sexually exploited, including online? Yes?
A. Yes.

Q. Sorry, I remember - if you don't say "yes" or "no" --
A. I'm sorry, I was reading.

Q. You haven't read this before?
A. Yes, I have. I was just refreshing my mind.

Q. Okay, thank you. What the facts of this case show is

that there was a disclosure made by a healthcare provider that Linda had had a ticket bought for her so she that could abscond interstate, the ticket having been bought for her by an adult who we can safely assume was proposing to exploit her; yes?
A. Yes.

Q. And, in fact, she went ahead and did that. Meanwhile, no-one realising she had left, a care meeting was convened to try and talk about how they could stop her absconding; yes?
A. Yes.

Q. This is obviously a case of a system not being able to protect a young woman from harm. What are your reflections on whether or not there were systems that could have done better or whether this is an example of an absence of suitable supports and options for a child in this position?
A. Thank you. In the first instance, what I would say is it appears to me, as someone who's not a Child Safety Officer, a police officer or an operational expert in any way, that there is an absence of options and authority to really prevent someone from absconding in this way, for the Child Safety Service. And, in terms of how it could and should have been managed, I would defer to someone with that level of expertise: Claire or a Sonya or someone like that.

In this particular case, I would like to understand, as the Secretary responsible, why we didn't try and intervene earlier, even though our options for intervention are very limited. And I think that's the step. It's clear there should have been earlier intervention; it's clear there should have been a more therapeutic approach.

Q. Can I suggest to you that two potential themes that emerge from this case study is firstly, there's clearly a delay and a lack of urgency on the part of the Child Safety Services and the residential care provider once they're on notice of the risk that she's had a ticket bought for her and might leave?
A. Yes.

Q. But secondly, it appears that this is a case where there wasn't any other kind of accommodation available for her, in distinction, for example, to arrangements that exist in some other states for other kinds of care for

children at extreme risk?
A. Yes, and we touched on that earlier around the idea of having a secure welfare option, and that would definitely be used as a circuit breaker. I could see the great benefit there, to have that circuit breaker so that there could be a direct therapeutic intervention.

Q. Thank you. Can I turn then briefly to case study 4, which is --

PRESIDENT NEAVE: Sorry, just before we do.

MS ELLYARD: Yes.

PRESIDENT NEAVE: The early history of Linda suggests that there could have been an intervention long before, because it appears - at least to somebody who has no expertise in this area, it appears at least that what her behaviour as she is later is directly related to what happened to her when she was very young. Under 10.

MS ELLYARD: Q. Do you accept that, Mr Pervan? If you look in particular at paragraph 3, there is evidence that Child Safety Services were on notice that she wasn't receiving therapeutic supports, but left her in that placement?
A. I agree with Madam President that, as someone with no qualifications or expertise, that's what the facts would appear to present.

Q. Thinking about the question of care concerns and so forth, let's say, God forbid, there's a highly damaged child living with a departmental carer now and the child's been assessed as needing therapeutic interventions and the foster carers are impeding the therapeutic interventions being provided; what would happen?
A. My assumption would be that if the foster carers could not be convinced to change their position, we would find a new placement for the child; that might be complicated by the fact that the child might want to stay with those foster parents, so we would have to keep working with them.

Q. Speaking as the child's parent, what would be your expectation for what would be done for that child?
A. My expectation is that they would give them access to therapeutic supports.

Q. Failing which, you wouldn't trust them with her care any longer?
A. That's correct.

COMMISSIONER BROMFIELD: I'm going to briefly interrupt as well.

Q. I assume you would accept that there is a lack of therapeutic treatment options?
A. Yes.

Q. That there's a chronic shortage?
A. Absolutely.

Q. I'm wondering if you've taken any steps during your time as Secretary, and I note previously when the two departments were actually combined with Health, whether there was any steps that you had taken to try and secure any priority access to treatment for children in out-of-home care?
A. Yes, I was the Secretary who triggered the review of the Child and Adolescent Mental Health Service in this state which was completed by Dr Brett McDermott who you've already met, who I met during the review of a particular case of a girl in out-of-home care and we brought him in to review her diagnosis and treatment. As a result of that review the plan for CAMHS with a particular focus on therapeutic and health supports to children in out-of-home care was accepted by government and its various actions and resources fully funded in last year's budget. So, he is in the process of recruiting more and more staff to deliver that care, but we now have funded, dedicated therapeutic resources for children in out-of-home care.

Q. Through that?
A. Through that initiative through Health.

Q. And my understanding of his evidence was that you would need still some kind of diagnosis. Would child sexual exploitation, and being under the manipulation of a perpetrator, make you eligible for that service?
A. To be honest, I'm not professionally competent to give you a reply other than to say, I would assume that the trauma that we're talking about and its manifestations would be sufficient to get them access to that therapeutic intervention. If you've got someone who is engaging in activities which are self-harming and self-destructive in

all sorts of other ways, I would assume that would be enough for them to at least get an assessment to see if there was an underlying mental health issue there.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Q. Can I turn then briefly to the fourth case study, Mr Pervan, in the interests of time and that is the case study of Orson and Ivan, and just at the outset, this is obviously a case of complete system failure; do you accept that?
A. Yes, I'm aware of the case, from the case study.

Q. Do you accept the proposition that this is a case of complete system failure, and I'm happy to expand on why I'm putting that to you if you don't feel able to accept it as a general proposition.
A. Yes, I would.

Q. So, this is a case of two children being placed together when there were clear warnings to Child Safety Services at the risk that that one child could pose to another; do you accept that?
A. Yes.

Q. This is a case where concerns were raised again after a period of time, again, concerns that one child was at risk of being sexually harmed by the harmful sexual behaviours of the other child; yes?
A. Yes.

Q. There was then a disclosure that in fact sexual assault had occurred and a care meeting was convened, not by Child Safety Services itself but by a service provider working with the child who had been harmed?
A. Yes.

Q. And it appears from a review of the file that there wasn't any action taken by the Child Safety Service, perhaps one can infer because the relevant Child Safety Officer left shortly thereafter; yes?
A. Yes.

Q. And so that the only action taken after a clear disclosure of one child being sexually harmed by another, was that the foster carers of their own initiative increased their vigilance around supervising the children?

A. Yes.

Q. And then inevitably the inevitable happened and the child was sexually assaulted again; yes?
A. Yes.

Q. And only after that time was there a referral to the Senior Quality Practice Advisor; yes?
A. Yep.

Q. And, even then, there was still a period of time where the determination was that the two children could keep living in the same house?
A. Yes.

Q. Then there's the third notification of abuse that's made after the children had been living in the same house and only then is the child displaying the harmful sexual behaviours removed from the house?
A. Yes.

Q. So there's two separate opportunities to intervene after the first series of sexual assaults; the children are left together and inevitably further assault occurs.
A. Yes.

Q. And that's in the context of, it would appear, no therapy being offered to the child displaying the harmful sexual behaviours; yes?
A. Yes.

Q. And indeed it'll appear from the file, a deliberate decision that the child can wait and receive such services from the NDIS once he's an adult?
A. Yes.

Q. And so, both of these children were in the care of the person at the time holding the office of Secretary, whether that was you or whether that was your predecessor?
A. Yes.

Q. And on any view, and this wasn't so long ago that previous attitudes and understandings applied, on any view an absolute failure to avoid preventable serious harm, really to both boys?
A. Yes. I agree that's the outcome.

Q. So, other than agreeing with me that it's a complete process failure and noting as you will be aware from the background material when this happened, my question to you is: with something like this happening, do you have confidence that children living in foster care in Tasmania are safe from the risks of harmful sexual behaviours?
A. I think children living in out-of-home care in Tasmania are safer than they were at this point. I think the discipline of the system around care planning and around assessment of risk is more robust. I think that the opportunity to access therapeutic supports through CAMHS, or even the direct involvement in a consultative way of Professor McDermott has radically changed our ability to assess risks --

Q. I'm sorry to interrupt you, Mr Pervan, and I'm loath to say too much because I want to avoid identifying these children, but the chronology attached to this case study reveals that this wasn't very long ago.
A. Yes, I know.

Q. So, when you're talking about, "We're much better off than we were", I'm concerned or I get the sense from your evidence that you suggest there'd be a different response now because of improvements, and I'm pushing back a little because of how little time ago these children's experiences were.
A. Yes. I think we're substantially better off than we were two years ago.

Q. Why? What's different from two years ago?
A. Two of the reasons have been in the room today: Sonya Pringle-Jones and Claire Lovell. We now have a dedicated Director of the Child and Adolescent Mental Health Service who has an understanding of these issues, and particularly of the challenges or risks of children in out-of-home care and is very, very focused on addressing those risks; and because our scrutiny and our ability of self-reflection through things like the Serious Event Review Panel, or Serious Event Review Team, has increased our capacity to identify and respond to risks.

This is awful. I am not trying to justify this outcome in any way, but I don't know what alternative placements were available for the child, I don't know what's not written, and once again we get to the issue of record-keeping.

Q. I'm sorry, Mr Pervan, but these documents were provided to the state with relevant attachments that would have assisted you to inform yourself and if you didn't get the chance, that's fine, but I really need to put to you very strongly, and it goes back to my question about whether or not you feel that foster carers could meet standards and the broader question about whether or not you can have any confidence that children are safe in care. This is incredibly recent and it's a repeated failure by Child Safety Services to intervene to protect a child from being raped.
A. Yes, I agree.

Q. And, I hear what you say and I don't wish to dismiss the hard work and competence of the people whose names you've mentioned, but what is it that's different about the system that would mean a different Child Safety Service response would happen today from the very recent past when these two children got the response that they got?
A. I've just provided that and I'm sorry it's not sufficient for you.

Q. Well, you've described people who know about risk, but those aren't frontline Child Safety Officers, are they?
A. No.

Q. And you've described a new and better system, and I'm conscious that you're engaged in a process of continuing reforms, but this is very basic stuff though, isn't it? I mean, this is an obvious --
A. I've also mentioned that sexual abuse has escalated to senior levels and involves more senior practitioners, which is a relatively recent change.

Q. Well, this case involved the senior quality practice advisor who was happy to leave the children in a placement together, after the first disclosures of abuse.
A. Yes, positions that we haven't had for a couple of years. I can't comment on that Senior Quality Practice Advisor's practice because I am essentially a senior administrator; I'm not a social worker, psychologist or a risk assessor. These are fundamental questions of practice and practice decision-making which would be far better placed with Claire Lovell or a senior practitioner responsible for the area.

Q. But ultimately --
A. I'm sorry, you are labouring the point. You may as well ask me why a surgeon used a particular device in a hip replacement when I was running a hospital.

Q. I'm asking you as the parent of these children --
A. In a fully delegated service. I am not a practitioner. I am not running away from the fact that I am the parent, and as the parent, as I would with one of my own children, this would horrify me, but that's an emotional reaction to this terrible outcome. I don't know why, and you've asked me the question, am I confident children are safe? No, I said they were safer. I'm not confident they're safe. It's a human system and human errors are made, but I'm not competent to comment or judge someone's practice; I depend on specialists.

You referred to having expertise on the Care Concern Panel. I would do exactly the same thing, I depend on people who are expert in these matters to provide me with advice on what is good practice, what's bad and what's totally unacceptable.

So, in this instance my reaction is a purely emotional one, as the parent, but if I was to investigate this I would have to bring in external expertise to tell me what's appropriate, what's inappropriate and what's totally unacceptable.

Q. On the question of reforms, Mr Pervan, you've made it clear in your statement that there are a large number of reforms either underway or in train already, and you foreshadowed that there are a number of ways in which you have an anticipation that those will improve the system.

One of the things that I'm sure you will be aware we've heard of from a number of people who have given evidence, is an impression that there's a lot of new things that come in but perhaps a lack of follow through. I think Ms Pringle-Jones talked about Tasmania being guilty of "partial reform". Do you accept that?

When one looks back over the course of Child Protection practice since perhaps 2013 and 2014, there seems to have been almost constant renewal or creation of new programs.
A. Yes, there have been and that's been in response to

usually cases and issues just like this; that a decision's been made by government, not by me, that our response is insufficient, could be more robust, needs to go in a new direction. The Strong Family Safe Kids reform group is probably the most sustained reform activity that I have been involved in since I moved to Tasmania 15 years ago.

Q. You'll have seen that some of the reflections from some of the witnesses were, so for example Ms Witt from CatholicCare said she felt like:

> *There were constant reforms when new ones begin before the previous one is completed.*

Her perspective was that it was sometimes about political point scoring rather than focused on outcomes. Do you have any comment on that?
A. No.

Q. And Mr Watchorn said that he reflected that he didn't know whether to be optimistic or think that this is groundhog day in relation to the news of the latest reforms. Does that resonate with you?
A. I can see why Julian would say that. I stay optimistic, it's why I stay working in this field. If I thought it was pointless, I would have looked for jobs elsewhere, but the work is important and when you can see the improvements that are occurring, notwithstanding that there is so much more to be done, it actually drives you to stay in there and hang in there for the reforms.

In terms of the strata'ing or the stratification of reform initiatives, legislation, national agreements and all that sort of thing, that's really a national phenomenon everywhere, and if I could - if I could - it would be great to consolidate all of the reform work that's currently underway into one package and have bilateral agreement across Parliament that we're going to do this, we're going to do it for five years and this is how we're going to publicly report on progress, and this is how we're not going to throw anything in on top unless there is an abundantly good reason; and that's a conversation that has to be held with the community as well.

Q. Now, of course, the ultimate proof of the success of any reform in this space will be an increase in the safety and wellbeing of children?

A. Yes.

Q. And so the key measurements are going to be the impact on children and of course the impact on the workers who work directly with children?
A. Yes.

Q. You said a little while ago that you can see the improvements being made. You're someone who was in this role and the parent of children in 2014 and 2015 and you're in that role now. Do you see that children are safer from sexual harm now than they were then? Are you confident of that?
A. I'm going to say, no, I'm not confident, and I am happy that I'm not confident because it means that I'm vigilant. If I was confident, I'd think we'd done enough or that the measures in place were sufficient. I don't think that will ever be the case. It's a terrible thing to admit that there isn't a regulatory framework or a resource or a review that's going to eliminate that horrible and terrible side of human nature that there will be always sexual predators out there and staying ahead of them is a never ending task. So, I would like to think that the work we're doing is improving their safety, but that won't stop. It's got to be something that is constantly attended to and, you know, through external oversight, independent oversight like Leanne pointing out that we haven't done enough and our systems aren't good enough, we need to be more collaborative, we need to work closer with police intelligence, we need to build on the Safe Families Coordination Unit to gather intelligence about any allegations around sexual misconduct or behaviour that might put kids at risk. It's a never ending task.

Q. I take your point about predators being always with us, but you will have seen from the evidence this week of - evidence of Muriel Bamblett from VACCA, Dr Miller from Mackillop, and Ms Sturges who all reflected in the context of evidence about the very considerable systems and trainings and monitoring arrangements that they had, that each of them use the metaphor of being to sleep safely or being able to sleep more safely knowing that they'd done everything they could to protect the children in their care.

Given the reflections that you've made, forgive me for asking, do you feel able to sleep safely as the parent of a

thousand children in a system which, as we've considered this week, isn't in a state that can give you any guarantee at all that those children are protected from sexual harm? A. No, and I don't sleep safely but, as I said, I don't think that's necessarily a bad thing because it means that I'm vigilant, it means that I am looking for opportunities to improve; it means that I am very mindful about the fact that, for all of the improvements I might see, for all the positive feedback I might get, all it takes is one Care Team to miss a fact, or one Child Safety Officer to overlook one report or one mistake.

In the safety and quality work that's undertaken in healthcare what you learn is that a catastrophic event usually has three poor mistakes - three poor mistakes - three poor decisions that lead to an outcome like that regardless of systems that are in place to avoid those decisions, so until such time as we can build a system that is more robust and that is completely integrated in terms of the information sharing around children in care with the people that need access to it, which is a barrier at the moment; if I was staying with the service I wouldn't sleep well until I was confident that everyone who had eyes on that child had access to all the information they need to keep that child safe.

MS ELLYARD: Thank you, Mr Pervan. Thank you Commissioners, those are my questions and I note the time.

COMMISSIONER BROMFIELD: I have no further questions, thank you, Mr Pervan.

PRESIDENT NEAVE: No further questions, thank you Mr Pervan.

MS ELLYARD: May I invite the Commission to step down for five minutes and then we'll return for the closing remarks?

PRESIDENT NEAVE: Yes, thank you.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Thank you, Ms Ellyard.

MS ELLYARD: We've now heard all of the evidence in this week of hearings relating to out-of-home care and it falls to me now to say a few brief words in summary.

Firstly and most importantly I want to express the thanks of the Counsel Assisting team and the whole of the Commission to the three victim-survivors who gave us permission to hear their stories and to use their experiences in the important work of making children in the future safer.

I want to thank Faye, who gave us permission to hear her story and to have it read into the record. Her story was a story of Child Protection being absent and not visiting even though there was a known risk. She reflected in her statement that she shouldn't have been placed in a position where it was for her to make a decision about whether she stayed in an unsafe position.

She told you about how she had to experience the brutality, frankly, of the Criminal Justice system. She recommended to you that Child Safety Services should have made the decision about risk and removal and not left it to her when she didn't know what the information was. She reflected that she needed a regular Child Safety Officer to build a relationship with so that she could have confided in them.

She reflected that the system needs more support for victims through the court process, and she also reflected on the need for support for children in schools through specialist training of teachers to equip them with how to support children and respond to disclosures. We thank Faye very much for sharing her story with us and we wish her well.

On Thursday we heard from Ms Beach. She described most poignantly to you how she was made vulnerable to sexual abuse because of the lack of warmth and love in her home. You recall she said:

I knew it was wrong love [the abuse that she was experiencing] but it was the only love that I experienced.

She reflected on how the abuse that she experienced has rippled down throughout her life, it's affected her relationships with her partners. She vividly said that it had skewed her love map, and it affected the way that she was able to parent her own children.

She described being re-traumatised by the Redress Scheme which she described as "disgusting". She described unconscionably long waits for redress or for civil action. She told you that she had sought to deal directly with politicians to try and get a remedy and response for what had been done to her. She reflected that no-one should have to chase up their own apology, and how true that is when a child has been harmed by the state as she was.

Part of Azra's experience was that she received a written assurance from the then Children's Commissioner that things were changing so that it wouldn't happen again. Sadly, not only does Ms Beach know from her own experience that that's not true, but there's plenty of evidence before this Commission to show that, however well intentioned that letter was, its promise hasn't borne fruit in the lives of children in Tasmania.

Ms Beach reflected that she'd been set up to fail and she asked you in her recommendations to learn from children who have lived in care.

This morning we heard from Mr Brett Robinson who told his story, a story about being taken from his home, a home where there was undoubtedly some troubles but where he and his father loved each other and where he felt safe and protected.

You heard from him that after a rough patch between Mr Robinson and his father, which involved arguments but no violence, Child and Family Services took him away for what was going to be a week but which turned into a six-month order, which a 12 or 13-year-old boy couldn't understand. During that six-month order he was moved around in placements including in a group home with children who were using drugs, and then with a carer who had no time or patience for him.

He was placed in respite care where there was an older boy who sexually abused him. All of this time he had a loving home that he could have been living in.

Mr Robinson told you that he told his carer what had happened but he wasn't believed. He told his parents and was taken to the police station but couldn't find the words to disclose what had happened to him, and so his life

spiralled, he moved from home to home, he ran away from placement to try and be with his father, he lived on the streets and then he turned to crime.

That criminal behaviour lead to him going to Ashley where his very first experience in the first hours and minutes of being there was being sexually assaulted during a strip-search. He was belittled and told he was worthless, he was physically brutalised and deprived of his rights. He was failed by all of the institutions that should have protected him. He was taken away from the trajectory of life he could have had, and his hope to you in evidence was that he can help other children, and he spoke most poignantly about the need for cameras everywhere in Ashley to protect children from harm. How sad it is that that would be necessary but how easy it is to understand why he would make that recommendation.

In addition to this, I thank Mr Robinson, I thank Ms Beach and I thank Faye very much for being brave enough to tell us their story and being generous enough to let us take the benefit of their experiences for the work that we are doing.

In all of the other evidence that we've heard, Commissioners, evidence from non-governmental providers, the Tasmanian Aboriginal Centre, former staff from the department, we've heard about many problems in the out-of-home care system, problems which directly and indirectly contribute to the risks of child sexual abuse and which contribute to poor responses to abuse after it has occurred. We thank all of those witnesses for participating in the work of the Commission.

Some of that evidence might invite you in the fullness of time to make findings about an under-resourcing across this important sector of work, an under-resourcing that leads to the absence of carers to meet the needs of children and for unconscionably and unsustainably large workloads for those trying to do the work.

You may find on your consideration of the evidence that there's a complete lack of sufficient systems to keep children safe; that there are cultural issues in the department charged with the responsibility for keeping children safe; that there are continuing issues about where decision-making power should reside for children in care,

including whether or not Aboriginal communities should have greater self-determination for their children, and how carers and children themselves can have their voices heard. And you've heard that there seems to be a lot of reform going on, but it's very unclear whether the frontline experience of a child or the frontline experience of a worker would have changed at all as a result of any of those reforms.

You've also had the benefit of evidence from a number of experts from other jurisdictions who have given evidence about models that work in other places and which may commend themselves to you as you consider your recommendations.

Of course, we've also heard about strengths in the system this week. You've heard from witnesses and heard about work being done by passionate and skilled Tasmanians who are providing good outcomes and who are supporting children in care. Witnesses talked about the vocation, really, of being a carer and the wonderful work that's done to keep children safe even when they've had sometimes horrific beginnings.

But there needs to be a system to support the work that those good people do and to make sure that anyone who doesn't have a vocation to this work and who doesn't wish children well is kept out of the system, and it's a poignant and painful reflection that, if the Secretary of the department, the person ultimately charged with the parenting of those children, albeit that he's assisted by his employees in doing so, if he quite frankly isn't able to say to you that he feels that the children in his care are safe, then clearly there's room for profound improvement in the system.

All of these now are matters for you as you consider your recommendations; recommendations which it's to be expected and hoped will provide for systemic changes that will help with the utterly essential work of keeping children in out-of-home care protected from sexual abuse.

If the Commission pleases.

PRESIDENT NEAVE: Thank you very much, Ms Ellyard, and we will now adjourn.

AT 3.50PM THE COMMISSION WAS ADJOURNED TO MONDAY, 27 JUNE 2022 AT 10.00AM