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

RFS-TAS-086

NOTICE TO PREPARE AND PRODUCE A DOCUMENT OR STATEMENT ISSUED UNDER SECTIONS 22(1)(b), 23(1) and (4) OF THE COMMISSIONS OF INQUIRY ACT 1995 (Tas)

To: Madeleine Gardiner
Former Manager, Professional Services and Policy, Ashley Youth Detention Centre

C/- [redacted]
Solicitor for the State of Tasmania
Commission of Inquiry Response Unit
Office of the Solicitor-General
Department of Justice
Level 3, 85 Collins Street
Hobart TAS 7000
[redacted]

A Commission of Inquiry established under section 4(1) of the *Commissions of Inquiry Act 1995* (Tas) (**Act**) is being held into the Tasmanian Government's responses to child sexual abuse in institutional settings (**Commission**).[1]

What you must do

You must produce the documents and things specified in enclosed Schedule, or prepare and produce a document or statement addressing any matters and responding to any questions specified in the enclosed Schedule:

Commission of Inquiry
Level 9, 144 Macquarie Street
Hobart TAS 7000
[redacted]

You must produce the statement, documents or things specified in the enclosed Schedule on or before **4.00 pm on 2 August 2022.**

Objecting to this Notice

You may object to the Notice by claiming that the document(s) or thing(s) specified in the notice are not relevant to the subject matter of the Commission's inquiry.

You may also object to this Notice if you have a reasonable excuse for failing to comply with the Notice. For example, it is a reasonable excuse to fail to comply with the Notice if you

[1] The Order of Her Excellency Professor the Honourable Kate Warner AC under section 4 of the Act establishing the Commission of Inquiry dated 15 March 2021, is set out in Annexure A to this Notice, and is also available to read at: https://www.commissionofinquiry.tas.gov.au/home.

have been charged with an offence in respect of that matter, unless that charge has finally been disposed of (sections 22(2)–(3), 23(2)–(3) of the Act).

If you wish to object to this Notice, you must do so in writing to the General Counsel by **4.00 pm on 22 July 2022**.

Your written objection must outline your reasons for objecting. If the Commission is satisfied that your claim is made out, the Commission may vary or revoke this Notice.

A failure to comply with this Notice without a reasonable excuse is a contempt of the Commission. It may constitute a criminal offence subject to a penalty of a fine or imprisonment (see sections 22, 31, 32 of the Act).

Dated: 20 July 2022

[redacted]

The Honourable Marcia Neave AO

President of the Commission

NOTES

Production of documents

To comply with this Notice to prepare a document or statement, please consult the Commission's Practice Direction 3 – Production of Documents and Document Management Protocol published on its website: https://www.commissionofinquiry.tas.gov.au/home.

Confidentiality and legal professional privilege

The Commission has published (and may continue to publish) practice guidelines on its website relevant to claims of confidentiality and legal professional privilege: https://www.commissionofinquiry.tas.gov.au/home.

SCHEDULE

DEFINITIONS

Any terms defined in the Order of Her Excellency Professor the Honourable Kate Warner AC under section 4 of the Act dated 15 March 2021 (**the Order**) have the same meaning in this Notice.

child sexual abuse includes, in addition to those things set out in the definition in the Order, allegations or incidents of inappropriate behaviour or misconduct which may constitute child sexual abuse, boundary breaches by an adult, and harmful sexual behaviour displayed by a child.

Detention Offence means an offence committed by a detainee as defined by sections 139 and 143 of the *Youth Justice Act 1997* (Tas).

harmful sexual behaviours includes sexual behaviour in children which can range from behaviours that are developmentally inappropriate or problematic in terms of a child's own development to those that are coercive or sexually aggressive towards other children or adults.

including means including without limitation.

Official has the same meaning as in the Order and includes members, officers, employees, associates, contractors or volunteers (however described).

Royal Commission means the *Royal Commission into Institutional Reponses to Child Sexual Abuse* established on 11 January 2013.

National Redress Scheme for Institutional Child Sexual Abuse means the scheme given effect by the *National Redress Scheme for Institutional Child Sexual Abuse (Commonwealth Powers) Act 2018* (Tas).

A. REQUEST FOR A STATEMENT

You should answer these questions based on your own knowledge. In answering the questions, you may refresh your memory by checking any document in your possession or which you can access.

If you have no knowledge to be able to answer a question, you are not required to seek out and obtain that knowledge. In that case, you can respond to the question with a statement that you do not know about the matter and cannot answer.

The questions are to be answered in the order in which they are asked. You can provide any additional information at the end of your statement.

The Background information contained in **Annexure C** is provided to assist you to understand why the questions are being asked. If you do not agree with any part of the background section then you should identify the area of disagreement in your statement. However, you are not required to respond to the Background section unless you have knowledge of a matter which makes you think that the Background section is incorrect or

incomplete.

General

1. **When did you first start working at Ashley Youth Detention Centre?**

   My first role was in a 6 month contract position from 31 July 2017- 26 January 2018.

2. **What was your starting role (starting role)?**

   Manager, Professional Services and Policy

3. **What were your duties in that starting role?**

   I was employed .7 Full time equivalent (FTE) in the position for a 6-month contract. As the position was .7 FTE. The other .3 FTE was filled by [redacted]. As this was a shared management position, the duties of the role was shared. I was responsible for oversight of the case management staff, the conferencing staff and process, and the programs delivered to young people in the Centre.

   I have attached the Statement of Duties for the role (attachment 1). However, as the role was shared, the dot points below describe the duties it was agreed were the key responsibilities of my role:

   - Under the guidance of the Manager Custodial Youth Justice, lead a multidisciplinary team to effectively support the development, review and implementation of relevant programs and case management strategies relating to the effective functioning of a youth custodial and rehabilitation service
   - Provide supervision and support to Professional Services and Policy staff.
   - Participate as a member of the Ashley Youth Detention Centre (AYDC) Executive Management Team in the development, promotion and implementation of the Agency's strategic direction for youth custodial and rehabilitation services.
   - Promote and contribute to quality improvement and assurance in services to AYDC clients, consistent with relevant standards and statutory requirements.
   - Provide consultation on complex cases with specific attention given to the processes for case assessment and management in community and custodial settings, with a particular focus on the integration of former detainees back into the community

- Assume a lead role in the development of quality assurance mechanisms that underpin a quality improvement program that is consistent with CYS plans and priorities.

- Contribute to monthly budget and key performance indicator reports and participate in performance reviews at the Centre.

- Foster continuing professional support and development opportunities for assigned staff.

- Actively participate in and contribute to the organisation's Quality & Safety and Work Health & Safety processes, including the development and implementation of safety systems, improvement initiatives and related training, ensuring that quality and safety improvement processes are in place and acted upon.

4. **Who did you report to and who reported to you in that starting role?**

This position reported to the Centre Manager. In my starting role this was Patrick Ryan as Centre Manager. In my starting role I had separate supervision with [redacted]. [redacted] was acting Director of Youth Services.

As manager PS&P the staff who reported to me were:

- Stan [redacted] - Case management Coordinator
- [redacted] – Conferencing Convenor (also known as [redacted])
- [redacted] - Programs Coordinator

5. **Describe the process by which you were recruited for your starting role, including**

(a) **how you found out that the role was available;**

(b) **whether you were required to submit a written application, and**

(c) **whether you were required to attend an interview and, if yes, who interviewed you?**

- I found out the role was available through a conversation with Mr Patrick Ryan and [redacted] The position was advertised on the Tasmanian state government vacancies jobs page.

- I submitted a written application addressing the Selection Criteria for the position. I attended an Interview.

- The Interview panel was [redacted] and I cannot recall the other interview panel members.

6. **At the time you applied for and obtained your starting role, did you know anyone who was already working at Ashley Youth Detention Centre? If yes,**

who and how did you know them?

Yes. I knew:

- [redacted] - I knew [redacted] in a professional capacity. In 2012 when working as a Clinical Nurse Educator for Children and Youth Services, I collaborated with [redacted] to develop and deliver a therapeutic program for young dads in AYDC. I also had contact with [redacted] when working as a NUM coordinating the fathers program.

- [redacted] - I knew [redacted] in a professional capacity when [redacted] was working as Programs Coordinator at AYDC, and I was CNE developing the AYDC young dads.

- Mr Patrick Ryan - I knew Patrick in a personal capacity. I am related by marriage to Patrick Ryan. Patrick is married to my sister, [redacted].

- [redacted] - [redacted] is my sister and worked in the kitchen/ stores area of AYDC.

7. **At the time you applied for and obtained your starting role, or at any time during your work at Ashley Youth Detention Centre, were you a member of any organisations or associations (for instance, community sporting clubs, service clubs)? If yes, provide details.**

No.

8. **What was/is your most recent role at Ashley Youth Detention Centre (if different from your starting role)? If you have held more than 2 roles at Ashley Youth Detention Centre, list all roles.**

- The most recent role was in a permanent role as Manager, Professional Services and Policy .7FTE. The duties were the same. The position was permanent rather than contract. I had to reapply for this permanent position and worked in this position from 26/3/2018- 22/9/2019.

9. **What were/are your duties in each of the roles you have held (if you held roles other than your starting role)? Who did/do you report to and who reported/reports to you?**

- The duties were the same. The position was permanent rather than contract. I had to reapply for this permanent position. I reported to Patrick Ryan.

  The same staff reported to me in this role- Stan [redacted], [redacted] and [redacted]. At times I also provided supervision for [redacted], who was on a return to work program. As well, this position provided oversight of social work students placements.

10. **If you held roles other than your starting role, describe the process by which you were recruited for any subsequent roles you performed at Ashley Youth Detention Centre, including**

(a) **how you found out the role was available;**

(b) **whether you were required to submit a written application, and**

(c) **whether you were required to attend an interview and, if yes, who interviewed you?**

- I was recruited to the permanent role of Manager, Professional Services and Policy in March 2018. I found out about the role from working previously in the role I was aware it was vacant and being recruited to. I submitted a written application addressing the selection criteria. I attended an interview with a Panel with members: [redacted] Sonia Pringle- Jones and [redacted].

Education, training and relevant professional experience

11. **At the time you began working at Ashley Youth Detention Centre what was the highest level of education that you had completed?**

- Master of Clinical Nursing, Child and Family Health specialisation.

12. **Did you have any experience in a law enforcement, corrections or detention environment before you began working at Ashley Youth Detention Centre? If yes, provide details.**

No.

13. **Did you have any experience caring for, or working with, children and young people before you began working at Ashley Youth Detention Centre? If yes, provide details.**

- Yes. I am a qualified Child and Family Health Nurse (CFHN). I have extensive experience working with children and families to support their wellbeing and health. I also worked with adolescents for four years in a teenage home visiting program, where I worked with adolescent parents, both female and male. In this role I addressed the health and social needs of the teenage young parents, as well as helped them to learn parenting skills and care of babies and children. In this role I worked with a multidisciplinary team working with young people who have experienced trauma, abuse and neglect, as well as working with young people learning about sexuality and healthy relationships. In this role I attended training and developed knowledge and skills to assess and respond to young people to support them to be safe, develop healthy relationships, and design care and interventions to support their health and development. This included significant experience with assessing and addressing sexual health needs of adolescents.

- As a Child and Family Health Nurse, I have also completed significant training in understanding children and young people's behavior, and identifying behavior through the developmental lens of attachment theory, neurobiology and brain development, to identify behavior that indicates a child has been affected by trauma and/ or attachment issues.

I am trained in a number of child development focused/ attachment informed behavior management approaches, and experienced using these in practice to support young people in their development. As well, as a CFHN I have participated in professional supervision of my practice when working with adolescents to ensure my practice approach is trauma informed and based on meeting the needs of the young person.

14. **Did you complete any further educational qualifications during your time working at Ashley Youth Detention Centre? If yes, provide details.**

Yes.

I commenced a Master of Social Work in 2019 (UTAS) whilst working at AYDC. I have since completed this qualification in 2020.

15. **Did you receive any induction or training when you began working at Ashley Youth Detention Centre?**

I received some basic induction training regarding security in the Centre from the security manager. There was no formal induction training given to me related to my role, policies and procedures or how the Centre operated.

I was provided a folder of information which contained information on a change program that was in place at the time. I sought out further induction as required from the training officer at the time, and participated in relevant induction training when new youth worker staff were inducted.

I also attended education on Foetal alcohol spectrum disorder.

16. **Did you receive any further training in the course of your work at Ashley Youth Detention Centre? If yes, provide details.**

I attended training that I arranged for myself:

Holding Firm- Australian Childhood Foundation – Trauma informed approaches to working with young people in Juvenile Justice.

LGBTQI training

Manager Essentials training

<u>Staff training and support</u>

17. **At any time during the course of your work at the Ashley Youth Detention Centre, did you receive training in any of the following:**

(a) **record keeping and reporting, including with regard to mandatory reporting as well as incidents of violence or other inappropriate behaviour by detainees or Officials;**

No

(b) **behavioural management techniques for detainees, including**

isolation, removal of privileges and use of restraints;

In mid year 2019:

- a one day training session by [redacted] on Control and Restraint training.
- A one day training on Disability awareness
- Training on Foetal Alcohol Syndrome Disorder FASD)

(c) **trauma-informed responses to detainee behaviour;**

- Holding Firm - the ACF training referenced above.

(d) **harmful sexual behaviours;**

No

(e) **de-escalation techniques;**

Unsure

(f) **personal searches;**

No

(g) **use of force;**

The 2019 one day training session by [redacted] on Control and Restraint training.

(h) **health and hygiene for detainees;**

No - but I did organise some oral health education for staff and detainees by Oral health Tasmania as part of a school holiday program

(i) **occupational health and safety;**

No

(j) **sexual harassment and discrimination;**

No

(k) **professional conduct in the workplace or codes of conduct;**

No

(l) **complaint and grievance processes; or**

No

(m) **disciplinary processes in relation to alleged misconduct by Officials.**

No

If yes, provide details.

Policies and procedures

18. **As far as you were or are aware, during the course of your work at Ashley Youth Detention Centre:**

(a) **What was the policy or procedure which governed the use of isolation facilities?**

I am aware of the existence of the policy that detailed the procedure that governed the use of Isolation, and I referred to this policy on occasion, if required. However, my role was not directly involved in the use of isolation, nor were the staff I supervised responsible or involved in decisions regarding use of Isolation, for this reason I am knowledgeable that the policy existed, but did not directly use this policy/ procedure in my work in the Centre.

(b) **What was the policy or procedure which governed the use of unit bound practices?**

I am not aware of a specific policy/ procedure related to unit bound practices. These decisions were made based on the colour level of young people based on the Behavioural Development System (BDS). My Understanding is this decision was made by the Operations Manager/ CST group based on a young person was on Red colour, and determined that there was a security risk with them being in the general Centre. My understanding is this was made on a case-by-case basis, by the Operations Manager/ Centre Manager/ Operations Coordinator or CST group.

(c) **What was the policy or procedure which governed personal searching of detainees?**

I am aware of the existence of the policy that detailed the procedure for personal searches of detainees, and could locate this policy if required. However, my role was not directly involved in personal searches of detainees, and no staff in my team or that reported to me conducted personal searches of detainees, so this was not a policy I directly used in my time in the Centre. Also, as my role was a shared management role, and oversight of management policy work was allocated to Mr Terry Whiteley, I did not have any management role or oversight of this policy.

(d) **What was the policy or procedure which governed the use of force towards detainees?**

I am aware of the existence of the policy that detailed the procedure that governed the use of force. However, my role was not directly involved in the use of force, nor were the staff I supervised responsible or involved in decisions regarding use of force. For this reason, I am knowledgeable

that the policy existed, but did not directly use this policy/ procedure in my work in the Centre. The staff in the PS&P team referred to using non-violent crisis interventions skills to prevent the need for the use of force when interacting with detainees.

(e) **What was the policy or procedure which governed the way in which Officials were to interact with detainees more generally?**

I am not aware of a dedicated policy / procedure that governed staff interactions with detainees. All staff in the PS&P team (myself and the staff that reported to me) were guided in the work in the Centre by the Youth Justice Act (1997) and made reference to the principles of the Youth justice act when working with young people in detention. As well in my role supervising the PS&P team and considering the interactions of officials with detainees, I was informed by the United Nations Rights of Children, and would often reference this when talking about the care and management of young people in the Centre.

(f) **What was the policy or procedure which governed the way in which Officials were to interact with each other?**

I am not aware of any specific policy/ procedure in this regard. I am guided to behave according to the State Service Code of Conduct and would ensure the staff working in my team were aware of the Code of Conduct and interacted with each other and other staff in the Centre according to this code of Conduct. As well, I am informed of the Anti-Discrimination Act when interacting with other people in the workplace.

(g) **What was the policy or procedure which governed detainees' ability to have visitors (for example, family, friends, legal representatives, external oversight)?**

I am aware of the Policy / Procedure for detainees that guided visitors to the Centre. This procedure was often referred to by the Program Coordinator staff and Case Management staff in the PS&P team, who organised many official and family visitors to the Centre (Attachment 3).

I did observe times when practice did not align with the visitor policy, when family visits were declined based on staff personal opinions, and there was no consultation with the PS&P staff. As well, it was reported to me by [redacted] that a professional visitor was refused entry for a prearranged visit to a young person, and the visit was refused based on the ground of the safety and security of the Centre, and the PS&P team staff were not consulted. In both these instances PS&P were not consulted, and the reason given for refusal did not appear valid, and young people were deprived of visits from supportive members of their family, or a supportive service provider. I have described details of these occasions further in point 77 (e).

(h) **What was the policy or procedure which governed the record keeping of incidents, including how incidents were classified?**

Yes there was an AYDC incident reporting procedure that I was familiar with as far as it related to my role (attachment 4). This procedure was the process for recording incidents involving detainees and detainees' behaviour.

I did not have any direct role in this procedure, however as member of the CST group I was aware of how and when incidents must be recorded. As well, in my role supervising the Conference Convener position I was aware of incident reporting required for the Conferencing process.

Incidents classification was determined by the seriousness, as either a Recorded Incident, Minor Incident or Detention Centre offence. Detention Centre Offences are defined by the Youth Justice Act (1997).

The Behavioural Development System (BDS) (attachment 2) described the classification of incident types.

I was also aware in my role as manager PS&P of incidents that required reporting related to workplace health and safety in the Safety Reporting and Learning System. (SRLS).

(i) **Was there any policy or procedure in place requiring the reporting of misconduct or potential misconduct by Officials, including in relation to mandatory reporting obligations? If yes, what was that policy or procedure?**

Not that I was aware of.

(j) **Was there any policy or procedure in place regarding mandatory reporting requirements in relation to conduct by Officials, detainees or others? If yes, what was that policy or procedure?**

I was not aware of any specific policy/ procedure regarding mandatory reporting by staff in the Centre. My understanding is that all state service employees are bound by mandatory reporting requirements according to the Children, Young Persons and their Families Act (1997).

(k) **Were there any other policies or procedures which were known to you and that you consider particularly relevant to Ashley Youth Detention Centre?**

In your answer, please identify where standard practice did not align with these policies.

19. **How were Officials made aware of and trained in those policies?**

The Training Officer ran an induction program, where staff were orientated to relevant policies in the workplace. However, I did not have oversight of this induction process, so I am unaware of the extent to which staff were orientated to these policies/ procedures.

20. **How was compliance with those policies monitored?**

Compliance with policies is the responsibility of each staff member, and their direct manager to ensure they are aware of the policy and comply with this. I am aware that at times, when a new policy was implemented, staff were required to read/ familiarise themselves with the policy. I am unsure how this was recorded, as I did not have oversight/ management of policy compliance.

Clinical Practice at Ashley Youth Detention Centre

21. **What did you see as the respective roles to be played by:**

(a) **the Professional Services team;**

(b) **the Health team;**

(c) **the Operations team; and**

(d) **the team working in the Ashley Youth Detention Centre school?**

22. **In your answer, please identify to which department these roles reported.**

a) The Professional Services team - provided Case management and rehabilitation support to young people, through assessment, professional support, coaching and mentoring, identification of rehabilitation pathways and programs, programs of recreation and wellbeing, as well as conferencing (conflict resolution, mediation and conferencing for Detention Offences under the YJ Act) as well as exit planning to reconnect with the community supports when returning to the community. As well, the Case management team prepared pre-sentencing reports. The Manager of PS&P chaired the Multi-disciplinary Team (MDT) meeting. According to the Statement of Duties, the Manager of PS&P was responsible for providing advice on complex case management. For this reason, it would be expected that the PS&P team would be involved in consultations on assessing and responding to complex issues regarding young people in the Centre.

Staff in the PS&P team reported to the PS&P Manager (Myself), The PS&P Manger reported to the AYDC Centre Manager.

b) The Health Team: Were nursing staff- Registered Nurses, who provided health assessment, advice and care planning and coordination and delivery of health care for young people in the Centre.

The health staff reported to the Nurse Unit Manager, who reported to the Forensic Health service in the THS.

c) The Operations Team- were the Youth workers who worked directly with the detainees/ young people in the Centre on a day to day basis, supervising their behavior, participation in rehabilitation programs and the school education. The youth workers reported to the Operations Coordinator they reported to on each shift.

The Operations coordinator reported to the Operations Manager, who reports to the AYDC Centre manager.

d) The staff in the AYDC school were teachers and teachers' aides who provided education and learning for detainees according to the school curriculum. School staff reported to the Ashely school principal, who reported to Learning Services North, Department of Education.

23. **What was the role of the Multi-Disciplinary Team (MDT)? What was the extent of your role/interactions with the MDT? Do you consider that the MDT operated in an effective manner?**

The MDT meeting met weekly on Thursday afternoon for 90 minutes. My understanding of the role of MDT was to provide a forum for multi-disciplinary assessment, case discussion, planning of care, and review of care for the young people in the Centre. This would include plans and programs to support rehabilitation, address health and education needs, address any challenges as far as behaviour, identify risks to the safety and wellbeing of young people, and make therapeutic recommendations and plans of care to address these.

As Manager of PS&P my role was to Chair the MDT meeting.

When I commenced as PS&P Manager, I did not believe the MDT functioned effectively. Some observations I had were:

- the meeting did not start on time, and often went 1-2 hrs over the allotted time.
- There was no clear facilitation/ chairing of the meeting, some participants dominated the discussion.
- Member would contribute input based on personal opinions, and outside of the scope of their role/ expertise. The meetings rarely made any therapeutic recommendations.

A review of MDT was done in 2018 by a Senior Quality Practice Advisor within the Quality Improvement and Workforce Development team of Children and Youth Services, and as a result new Terms of Reference were created. (attachment 5). With the New ToR, the meeting was chaired using a strict agenda, time keeping and meeting group facilitation and chairing process was established. As well, I introduced the Children and Youth Wellbeing framework (attachment 6) as an evidence informed framework to guide the MDT discussion focused on the needs of the young person. This was also used as a template for minutes recording. This had some success in keeping the meeting discussion focused on the wellbeing needs of young people.

Using this approach I noticed an improvement in the recommendations and outcome of the meetings for care of young people, but I am not sure if this actually translated in changes in practice or improvements in care of young people in the Centre, as this would require the Operations team to action the recommendations. I received feedback that the recommendations of the

meeting was not always successfully communicated to the Youth workers working with the young people. This was further complicated by the culture of the teams in the Centre.

24. **What was the role of the Centre Support Team (CST)? What was the extent of your role/interactions with the CST? Do you consider that the CST operated in an effective manner?**

The CST Team met every Monday morning and reviewed the behaviour and incidents of detainees over the past week. The CST was responsible for determining the colour level a young person was on in the Behaviour Development System (BDS) as well as approve or not approve the programs young people participated in, identify safety and security needs of young people and the Centre, approve or not approve the requests of detainees, as well as identify any changes to unit placements of young people.

In my role as Manager of PS&P I was required to attended CST as a standing member. If there was no Operations Manager available, and no Acting Operations manager, according to the ToR for CST I was required to Chair CST.

At times CST operated effectively as a decision making forum. CST was definitely driven by the agenda of the Operational Team, such as Youth workers, Operations Coordinators and the Operations Manager. I do not believe CST was safe place to discuss alternative views by other teams in the Centre, as the membership was very heavily comprised of Operational staff.

25. **How would you respond to the suggestion that the CST operated in a manner that was punitive and which did not pay appropriate regard to the views expressed by the MDT?**

I would agree with this opinion. I agree with this because the CST is based on the BDS- and the BDS is a behaviour management system that uses punishment and rewards, so can essentially be punitive if used without context to the therapeutic needs of young people. CST did not consider or incorporate the views of the MDT group.

26. **Describe the relationship as you perceived it between Operations Officials and Professional Services Officials at the Ashley Youth Detention Centre.**

The relationship between these officials when I commenced as manager was described by both teams as conflictual. There was a Change Manager in 2018 who conducted some relationship building exercises to bring together different teams. When this position stopped there was no focused effort to build relationship across the teams. At times I believe I built respectful relationship with other Operations staff, however, I noticed significant conflict continued between staff across the two different areas, and this never improved. I was told by another manager in the Centre that "Operations run the Centre". I disagreed that this should be how the Centre runs, as collaboration across the teams would be best practice, but this was disagreed with.

27. **Describe the relationship as you perceived it between Operations[1] Officials**

and Health Officials at the Ashley Youth Detention Centre.

I did not often observe this relationship, so cannot comment.

28. **Describe the relationship as you perceived it between Health Officials and Professional Services Officials at the Ashley Youth Detention Centre.**

As manager of the PS&P team, I believed I had a good relationship with the Health team, and respect for their knowledge, skills and contribution to the Centre. I believe my team members also respected the staff in the Health Team, and had a good relationship with them.

29. **Describe the relationship as you perceived it between Professional Services and senior management at the Ashley Youth Detention Centre.**

The staff I managed reported that historically there was significant difference of opinion between the professional services team and the senior management of AYDC.

My initial experience working with senior management of AYDC was positive in the first 6-8 months of my position working at AYDC. At this time there was a Change Manager ([redacted]) and the Centre Manager (Patrick Ryan). The Change Manager was tasked with designing and developing a model of therapeutic service delivery in AYDC. The work of the Professional Services team aligned well with the change direction of a therapeutic approach. The Change Manager facilitated some relationship building workshops involving all areas of the staffing groups of AYDC. I considered this had a positive effect on relationships. The position was not funded after 30 June 2018.

Over the course of my employment as Manager PS&P, the staff in the Professional Services Team were often required to advocate for the rights of children in the Centre, and at times this put the staff in the Professional Services team in conflict or difference of opinion to the senior management team. Over the course of my employment, I noticed a decline in the relationship, to the extent that there were instances of practice that the Professional Services team should have been made aware of or involved in decision making, and they were excluded from this. At other times, advice from the Professional Services team was disregarded or ignored/ not responded to by the senior management team and Centre Manager.

30. **Describe the relationship between Officials based at Ashley Youth Detention Centre and management at the Department of Communities.**

The Director of Custodial Youth Justice at the time I worked at AYDC was first [redacted], and then [redacted]. Both [redacted] and [redacted] made efforts to be present in the Centre on site from time to time. I cannot really comment on the general relationship of officials in the Centre to management in Department of Communities a I didn't observe anything to inform an opinion.

31. **What was the 'AYDC Model of Care'?**

(a) **Was it in use during your time at Ashley Youth Detention Centre?**

(b) **If so, how did it operate?**

My understanding is that the AYDC Model of Care was a proposed model of care that was being developed by a Senior Quality Practice Advisor (SQPA) [redacted], in consultation with AYDC management and staff, to develop a model of practice to guide the work of staff in AYDC to provide rehabilitation and care to the young people in the Centre. It was intended to follow on from the initial work developed by the Change Manager.

In my time working at AYDC it did not progress past the stage off a draft proposal for a Model of Care. It was not implemented.

Culture

32. **What was your understanding of the philosophy underpinning the way children detained at Ashley Youth Detention Centre were to be treated?**

The way children were treated in AYDC is guided by the principles of the Youth Justice Act (1997). Staff also spoke of working in a trauma informed practice approach.

In my experience the AYDC did not have an explicit philosophy underpinning how children were to be treated that was communicated to staff and that staff acted according to.

When I commenced at AYDC developing a philosophy that guided practice for staff was a focus of the Change Manager and was in development with an Ashley Approach working group. This group was developing an approach that would be informed by the trauma informed care, child development principles, and underpinned by attachment theory. This was never progressed after the Change Manager position ceased in 2018. After this, staff attended training in "trauma Informed practice" and on occasion a staff member may have referred to working in ways that were "trauma Informed' but this was not an explicit or philosophy that was referred to in decision making and to guide practice.

33. **Do you consider that all Officials worked with children in a manner that was consistent with that philosophy?**

I do not believe all officials worked with children according to the principles of the Youth Justice Act (1997). Many times, I considered that the priorities of the Operational staff were put before the needs of the children, and while this is always a consideration in service delivery and the security and safe running of the Centre, the operational need appeared at times to take priority over the rehabilitation needs of the young people.

Whilst the staff referred to being "trauma Informed" I observed in practice this did not translate. For example- I was told by an acting Operations Manager to speak to a young person and tell them to "stop lying". I explained that I would not tell a child or anyone to stop lying, as this is not trauma informed, or informed by child development theories. Rather, I would endeavor to find out why they felt they needed to lie and did not feel safe to tell the truth. I

requested a Senior Quality Practice Advisor (SQPA) to run a consultation session with the staff working with this young person, to identify the likely reasons the young person may use lying or not telling the truth, and also to do some staff education on the development and function of lying for young people, and particularity young people affected by trauma. Another example is that verbal aggression and physical aggression are often behaviours that result from trauma when young people don't feel safe or experience a threat. The current BDS punishes any forms of verbal abuse/ physical aggression. A trauma informed approach would be to prevent experiences of threat to young people, as well as support them to regulate their emotions and manage their behaviour in a regulated state. Some staff were very skilled at this, other staff were very punitive towards detainees when / if their behaviour escalated.

In my interactions with the management team and operational staff there was never any reference to the United Nations Rights of Children, and there appeared to be very little understanding of the UN Rights of Children, what these are, and how these rights would be interpreted into the care of children in the Centre. There did not appear to be an understanding by many of the Operational management or Operational staff (Operational coordinators & Youth workers) that the young people in the Centre required special protection and consideration of their needs, due to the vulnerability of their age and level of maturity.

34. **How would you describe the culture at Ashley Youth Detention Centre during the course of your employment? Did this culture ever change, if yes please explain how it changed and what in your view caused or contributed to the change.**

As described in point 29, my initial experience working with staff in general and senior management of AYDC was positive in the first 6-8 month working at AYDC. I attribute this to the fact that at this time there was a Change Manager ([redacted]) working with the AYDC management team and staff. The Change Manager was tasked with designing and developing a model of therapeutic service delivery in AYDC. As well, the Change Manger facilitated a number of workshops to develop staff self- awareness, communication skills and develop relationships across the teams working in the Centre. I noticed this was effective for creating a culture of working together across all areas of the Centre, to improve the way the Centre operated to align with a therapeutic approach to care and service delivery for the young people in the Centre. The work was informed by the United Nations Convention on the Rights of the Child, the Youth Justice act (1997), child development theories, amongst others. The work of the Professional Services and Policy Team aligned well with the change direction of a therapeutic approach, and this change approach aligned with my professional knowledge, skills and values. At this time there appeared to be a sense of enthusiasm from staff in the operational team (youth workers etc), Health staff, school staff and the staff in PS&P to work together to improve the approach to working with young people to move to a more therapeutic informed approach. .

The Change Manager position was not funded after 30 June 2018, and I noticed that without someone driving the cultural change and relationship building

from a leadership perspective, this cultural change was not maintained.

Over the course of the 2019 year, the Centre had some detainees that created challenges to the safety and security of the Centre. At times this put the staff in conflict or difference of opinion to how best this could be managed. This conflict was not effectively managed by the senior management team. The senior management team, led by the Centre Manager did not function effectively as a team. For example, in the second half of 2019 I became aware of meetings and discussions that were held that excluded some managers (myself, the training officer), as well as decisions that were made by members of the Senior management group that did not consult other member of the group. Over this time, I noticed an increasing divide between operational managers and other areas of the Centre, and subsequent change in culture in the Centre.

35. **How did you view and experience the workplace culture at Ashley Youth Detention Centre? Do you think all Officials experienced that culture in the same way or were there differences depending on the specific roles fulfilled by the Officials working there?**

When I commenced working at AYDC in 2018, my experience of the workplace culture at AYDC initially, as described above, was of an appetite for change and working together, this was in the first 6-10 months of my employment there. This I attribute to the Change Manager and change program that was facilitated, that ended in June 2018. Throughout 2019 I noticed a change in workplace culture, and this was possibly a shift to the past culture- there was an increasing divide between the operational staff and the professional services staff. This was seen by differences in professional opinion on the way detainees should be managed and this resulted in conflict that was not addressed or resolved across the PS&P team and the Operational team. At all times when I worked at AYDC I did get a sense that the Operational team did not respect the input or roles of the PS&P team, and that the decisions in the Centre were ultimately made by the Operational team. Towards the end of my work in the Centre I noticed significantly less involvement by the PS&P team in decision making in the Centre. This culture was communicated to me by the staff in my team.

I think the culture was experienced differently depending on the roles people fulfilled, and also the relationships they had with others in the Centre.

<u>Behaviour management</u>

36. **Describe the behaviour management system in place at Ashley Youth Detention Centre and the role you played (if any) in its establishment, maintenance and review.**

The behavior management system was a colour based system called the BDS (Behavior Development System). It was designed to provide incentives to move up colours and reward good behavior through increased privileges/ and to discourage poor behavior by removing privileges. The colour represented the level of points a detainee obtained, and this described the type of privileges they received, in order of highest to lowest was green, yellow, orange and red.

Green had the highest privileges, and Red the lowest privileges.

I did not play any role in its establishment- it was established many years ago. I was involved in the maintenance / use of the system when attending the CST meetings to determine what colour a young person would be on for the next week.

I attended the BDS review committee meetings on a few occasions when working at the Centre in my role. My role as part of the review process on the committee was to contribute to the quality improvement of the BDS.

I did not experience the BDS review committee as a well-functioning committee.

For example, at one of the BDS review meetings I tabled the suggestions that the BDS be reviewed to identify improvements that can be made to make the behaviour management system more trauma informed. I explained that the BDS in its current form did not align with trauma informed practice, that it is an out of date model of behaviour management, based on behaviour modification theory (operant conditioning) that uses reinforcement and punishment to modify behaviour. The reinforcement is through the reward of increasing privileges, and the punishment is through removal of privileges. It is recognised by leaders in trauma recovery (eg the Australian Childhood Foundation) that this form of behaviour management is not suitable for children affected by trauma. This is because principles of trauma informed practice and neurobiology of trauma recognise that behaviour is a form of communication, that young people who have experienced trauma communicate their needs through behaviour, and behaviour is a way to get their needs met. This also aligns with attachment theory. This was not well received by a member of the meeting group, who became verbally aggressive towards me, and used nonverbal behaviour such as eye rolling and sighing to communicate their disagreement. This resulted in some conflict amongst all the meeting members. This meeting was chaired by [redacted], the unprofessional behaviour and the differences of opinion was not addressed, and the meeting was called off due to the conflict.

37. **What was the 'blue' system? In what circumstances was it used?**

I was unaware of the Blue Colour system until it was introduced in March 2019. Prior to this time, I had no knowledge of the Blue colour category. I became aware of the Blue colour as a category in a phone conversation with Mr Patrick Ryan. Mr Ryan advised me he had asked [redacted] to introduce the Blue colour system to the BDS. My understanding is that the Blue colour was reintroduced as a system to manage some detainees whose behavior was creating a safety and security risk to the Centre.

38. **Describe any changes to the behaviour management system during your employment at Ashley Youth Detention Centre, including in relation to the introduction or re-introduction of the 'blue' system on 7 March 2019 and any review of that program during 2019.**

As mentioned in point 37, the Blue colour was reintroduced in March 2019 by Mr Ryan and [redacted]. The first formal advice I received about this was in an all staff memo sent by email (attachment 7). I was not consulted on its reintroduction. I was made aware of this by a phone call advising me by Patrick Ryan, and then and reading the memo sent to staff on 7/3/2019.

I was first made fully aware of the content and structure of the Blue program in a discussion with [redacted], and in an email on 12 March 2019 from [redacted]. (see attachment 8 email named Blue and Red colour incentive). When I was made aware of the content and structure, I raised this with members of my team, as well as with Mr Ryan in an email on 18 March 2019 with some suggestion to improve the program to provide support to young people to met their developmental and trauma needs. (attachment 9 – email named FW Blue and Red colour incentive). My suggestions for a review of the program content and delivery, and suggestions for improvement and were informed by neurobiology of trauma and attachment theory. The delivery would be by qualified staff, such as the case management staff, psychologist and school staff, and utilises resources and consultation with specialist services such as the Australian Childhood Foundation, as experts in trauma informed care. I suggested individualised intensive programs that were based on relationships with young people, as trauma informed approaches are relationship based, not content-based programs. I was also concerned that young people on the Blue program were being deprived of school and educational learning opportunities, that is their right under The Youth Justice Act, and UN Convention on the Rights of the Child.

39. **In your view was the behaviour management system:**

(a) **appropriate; and/or**

(b) **given proper effect by Officials?**

a) No it was not/ is not appropriate, as it is not informed by contemporary research and theories about child development, attachment theory or trauma informed practice. As described in point 36, the BDS is behavioural modification system based on the theory of operant conditioning, which uses rewards (provision of privileges) and punishment (removal of privileges). This theory may have been relevant at the time of the BDS initial development, but it is not contemporary best practice now. It does not take into account that behaviour of young people who have experienced trauma is based on limbic system response that are often outside of their choice or control. A more appropriate BDS would take this into account and would assist young people to learn to develop self-regulation. In this way young people would be able to start to learn to regulate their emotions and their behaviour. I did speak about this when working in the Centre, but it did not appear to be received or understood by other staff that did not work in my team. I also explained this to the Centre manager, with no response.

I advised Patrick Ryan in conversation a number of times of this opinion, and that I was aware of a South Australian Model of behaviour management that I had seen a presentation on at the AJJA conference in May 2019. The South Australian model is much more aligned to Trauma informed practice, and increases support when behaviour deteriorates, does not impose punishment or removal of privileges, rather it provides increased individualised support when young people need this. I received a verbal response that this would be considered by Patrick Ryan, however this was never progressed in my time working at AYDC.

b) The BDS was often well followed by officials, but it was also open to much interpretation of behaviour, and differences in staff tolerances of behaviour by detainees. This is where young people often reported unfair practices due to staff personal interpretation of behaviour and consequences, and I was aware that young people felt that some staff were harsher or more lenient on some detainees than others.

40. **What was the Behaviour Development System Review Committee?**

(a) **What was its membership?**

This is described in section 3, page 5 the BDS protocol. (attachment 2) that states the Behavioural Development System review Committee membership "is to include at least the following standing representatives";

- Operations Manager
- Operations Supervisor
- Manager Professional Services and Policy
- Case Management Coordinator
- Operations Coordinator (on duty)
- Youth Workers/s Representative
- Project Officer (Chairperson)
- Programs Coordinator
- Fire Safety & Security Coordinator
- AYDC School Principal

Other stakeholders may be invited to attend BDSRC meetings by the Chairperson if they are able to assist in the on-going review of the BDS.

(b) **What was its function?**

A committee designed to review the BDS and make suggestions for changes/ improvement based on feedback from staff and detainees.

Section 3, page 5 of the BDS guide (attachment 2) states the purpose is:

The Behaviour Development System Review Committee (BDSRC) will monitor the operation of the Incentive Scheme and the Incident Management Scheme and modify practices as necessary. This group is to meet bi-monthly.

(c) **What role (if any) did you play in the work of the Committee?**

I attended meetings in my role as Manager PS&P. I provided professional opinion, offered suggestions for improvement and provided information as requested to committee members. My Professional opinions and suggestions were informed by my education and training in a number of contemporary approaches to understanding children and young people's behaviour. As mentioned at point 36, suggestions of considering more contemporary, evidence informed approaches to manage or respond to young people's behaviour was not well received by some members. Differences of opinion and conflict that arose was not well managed by the Chair, and as a result I did not consider it a well-functioning committee.

(d) **How was the work of the Committee regarded by Centre management?**

I am unsure. The meeting often seemed to not get enough membership to provide a quorum for the meeting to go ahead, and often seemed to be postponed or cancelled.

Detainee behaviour

41. **In what circumstances were Officials required to make a formal record of or report an incident involving detainee behaviour?**

According to the Incident reporting policy (attachment 4) and as further detailed in the BDS guide (attachment 2).

Also I understood that Youth workers in unit recorded a shift record of behaviour of the young people they were supervising.

42. **How were such records and reports made? Where were they stored?**

I did not supervise staff making records of detainees behaviour. But my understanding is they were made by:

- The Shift record – was a hard copy diary entry that was kept in the office of the unit, and Youth workers recorded any relevant behaviour in this.
- The Daily point sheet was completed by Unit staff on morning, afternoon and night shifts to record behaviour for the BDS.

Incident report forms were completed in hard copy for any incident that a staff member identified met the criteria as a "recorded Incident" a "Minor Incident" or a "Detention Centre Offence". I am not sure where these were stored. But I am aware a register of Detention Centre Offences was required to be kept. I understood this was maintained by administration staff.

43. **What training did Officials receive in how to assess, make, receive and act upon such records and reports?**

My understanding is this was delivered by the Training Coordinator. I was not involved in this training, I was not trained in this, and I did not have any oversight of this training.

44. **What role did you have, if any in supervising the making of records and reports by Officials or in training those who were under the obligation to make incident reports?**

I did not have any role in this.

45. **Do you think that Officials understood how to make incident reports?**

I am unsure. I cannot comment as I was not trained in this myself, and I did not supervise any operational staff who were responsible for making incident reports.

46. **Do you consider that the system of making and assessing incident reports worked to ensure that detainee behaviour was appropriately monitored and responded to?**

I observed the system served a function for reporting to the CST regarding incidents of detainee behaviour. I cannot comment on how accurate this was or effective in reporting incidents. The system was open to personal interpretation of incidents. It was a paper-based system, so has issues of being less transparent as an online reporting system, as paper based reporting can be altered without record.

47. **How would you respond to the suggestion that some detainees received favourable or unfavourable treatment from Officials depending on whether Officials liked or disliked them?**

Yes, I would agree with this.

48. **How would you respond to the suggestion that some detainees were singled out by Officials for unfavourable treatment because the detainee was disliked?**

I would agree with this. There was an appeal system in pace in the BDS, and a detainee could lodge an appeal to the CST group if they believed they had been unfairly treated. I observed many appeals by young people related to perceptions of unfair treatment. I also heard young people speak about this at times. As mentioned in point 39 (b), the BDS was open to individual interpretation by staff.

I would add that at times this may not be intentional, but this is something that can happen to any staff working in health and human service in challenging environment. This is why high-quality professional supervision is an important part of supporting staff to work with challenging clients. The supervision allows staff to reflect on their own difficulties working with challenging clients, and then identify how they can respond and work with fair, just and safe practice. High quality supervision was not part of the general practice at AYDC when I worked there, and I am not sure its role and function was well understood by the senior management group. As a supervisor of staff, I provided professional supervision to the staff in my team.

49. **Did you ever witness behaviour by a detainee, or detainees, towards another detainee which involved physical violence or sexually inappropriate behaviour, including the use of sexually suggestive language? If yes, provide details.**

I witnessed this when reviewing footage of an incident of sexual assault detailed in points 87-93 of this document, and referenced in emails of annexure I.

My role was not very often in direct observation of young people. When I was in direct observation, I was required to ensure it was safe to be present, so my encounters with the young detainees were usually at times when there was calm behaviour. I do not recall any specific occasions that I witnessed this in person.

50. **Did you take any action in response to what you witnessed? If yes, provide details of the actions you took. If no, explain why you took no action.**

Yes, on every occasion I witnessed or was made aware of a behavioural issue, I believe I took appropriate action.

In the instance described above, which relates to points 87-93. I made recommendation at the CST meeting on Monday [redacted] 2019 regarding what I thought was required to occur. This was not followed.

I took further action within my area of influence and control:

- On Tuesday [redacted] 2019 I sent an email to the CST group and Centre Manager (Patrick Ryan, [redacted], Hugh [redacted], Louisa [redacted] or Chester [redacted], presenting my opinion on what should occur regarding the management of the detainees who were involved. I did not receive a response to the email from anyone in the email group. You will note I received no response for over 7 days. (This is the email referred to in annexure I)

- I spoke to [redacted] to advise the parents of children involved in the incident.

- I spoke to the psychologist [redacted] to provide psychological support to the victims.

- On Wednesday [redacted] 2019 I requested a response from Patrick Ryan, Centre Manager, asking if this decision and management had been

reviewed, and had the Child Safety Service been advised. The Response from Patrick Ryan I considered unsatisfactory - Mr Ryan referred to varying views, a conference would be arranged and the psychologist [redacted] would provide literature for staff in the format of a poster display. Mr Ryan did not consider a Child Safety notification was required, but would "take argument"

- I notified the Child Safety Service of the incident, and requested that the CSS notify the police.

- On Thursday [redacted] 2022 I provided further advice to Mr Ryan by email with information on national guidelines and definitions of problem sexual behaviour in children and young people, and explained that differing views of staff should not guide practice, rather decisions in practice need to be informed by evidence informed practice standards. I suggested staff required education according to these standards. In his email response Mr Ryan did not respond to staff education suggestion, and made further reference to differences of opinion and subjectivity in these matters.

51. **Did you ever receive reports or information from other Officials or from detainees about behaviour by a detainee, or detainees, towards another detainee which involved physical violence or sexually inappropriate behaviour, including the use of sexually suggestive language? If yes, provide details.**

I would have been made aware of incidents where this occurred as part of my role attending the CST group. Instances of physical violence were common reports in the Centre, due to the fact that many of the detainees have experienced trauma, and use of physical violence is used as a fight or flight response. I cannot recall specific instances. As a member of the CST group, these instances were documented in an incident report form and considered by the CST group for how this will be responded to. My understanding and memory form this time was that both these types of behaviour would be recorded as a Detention Centre offence, under the Youth Justice Act (1997).

52. **Did you take any action in response to what was reported to you? If yes, provide details of the actions you took. If no, explain why you took no action.**

The actions I took depended on the type and degree of the behaviour. My role and my interactions with young people meant that if a behaviour occurred that required reporting, this would usually be completed by the youth worker assigned to work with the young person. My role as member of the CST group was to ensure the response to the reports of such behaviour was appropriate.

<u>Placements and Unit Bound</u>

53. **The Commission has received evidence suggesting the inappropriate placement of detainees in different units within Ashley Youth Detention Centre, both in relation to placement of detainees in units with other**

detainees and detainees being unit bound as a method of behavioural management by the CST.

(a) **Who was responsible for deciding to place detainees in particular units and how were decisions to place detainees in specific units made?**

In my time working at AYDC I understood that the decisions for unit placement were made by members of CST at the end of the CST meeting that occurred on Mondays according to the policy "unit commissioning and de-commissioning" (attachment 11). In my experience, this decision was made by collaborative discussion and some consensus. A change to unit placement could also be made through an Interim CST (ICST) meeting, which was meeting of CST members before the next CST meeting, which could be called anytime. In practice, unit changes were also made afterhours by an Operations Coordinator / Operations manager with approval from the Centre Manager.

I observed that when Unit placements changes were made at the discretion of operations staff only, and did not include members from other teams (e.g. PS&P) that at times these decisions made about unit placement put young people in unsafe arrangements, was not informed by MDT opinions, and that this was not in the best interest for their wellbeing.

Annexure J contains an example of an instance where a young person ([redacted]) was placed in a unit that was not suitable for him, and placed him at risk. This decision was made by and Operations Coordinator, outside of the CST/ ICST process. See annexure J with attached email re [redacted]s unit placement dated [redacted]2019.

Following this example of a unit placement decisions that placed a young person at risk, I raised the issue in a conversation with Mr Ryan that unit placements made by Operations Coordinators outside of the CST/ ICST process placed young people at risk. I explained that this single- person decision making process meant that decisions made may place young people at risk, and did not always consider the recommendations or opinions of PS&P staff and also MDT members, such as the psychologist. I was advised by Mr. Ryan to read the "Unit Moves" policy, which I did review (attachment 11) , and I advised him that the policy in its current form and the practice interpretation by operational staff placed young people at risk, and needed reviewing. In response to my statement, Mr. Ryan raised his voice at me and repeated that I need to read the policy.

(b) **Were unit placement decisions reviewed and, if so, how often were these decisions reviewed?**

Unit placement were reviewed weekly at the CST meeting, or between a CST meeting at an Interim CST meeting if this was scheduled.

(c) **What factors were taken into consideration when unit placement decisions were made or reviewed?**

In my experience decisions made by the CST/ ICST group were made informed

based on the safety and security of the detainees as well as considering the personality of detainees, and any conflicts that may exists between detainees that could contribute to safety or wellbeing issues for detainees (the factors are included in the relevant policy in attachment 11). The policy states that male detainees must be placed in separate units to female detainees.

(d) **What does it mean for a detainee to be 'unit bound'? Is it the same as being on the 'blue' system? Were there policies or procedures dealing with, and/or guiding the application of, a detainee being unit bound?**

I was not part of the design of "unit bound" or the design of the "blue program" when they were introduced. There was no formal consultation on how this was introduced or used with myself, and I am not aware of any other formal consultation occurring with other senior managers at AYDC. My understanding is that 'Unit Bound' and being on colour 'Blue' on the BDS was the same, which I learnt from an email from Patrick Ryan on 4.9.2019 (attachment 12) that was a response to the Commissioner for Children explaining that for a young person to be 'Unit Bound' was part of the Blue colour of the Behaviour Development System (BDS). This definition of Blue and "Unit Bound" was never communicated clearly to myself until this time. My understanding and observation of the "Unit bound" or "Blue color" was that a young person was not in isolation but was confined to the unit for parts of the day, they did not participate in the general activities of the Centre, and they received individual timetabling of activities. I understood that the young person was escorted to use the gym or other areas of the Centre, when it was possible to do this, to ensure the safety of the Centre was not compromised. I am not completely clear on the parameters of 'Unit bound' practices, as there was no policy/ procedure at the time regarding a detainee being 'Unit Bound' and as can be seen in the response to the Commissioner for Children, this practice was used at the discretion of the Centre Manager, to maintain safety and security of the Centre.

(e) **Who was responsible for making decisions about detainees being unit bound?**

My understanding is that this was made by the CST or Operations coordinator/ Operations Manager with approval required from the Centre Manager. When the decision was made at CST, it was heavily influenced by the opinion of Operational staff to maintain safety and security of the Centre.

(f) **What factors were taken into consideration when making a decision to unit bound detainees?**

My Understanding is this decision was only made when it was required under the discretion of the Centre manager under the Youth Justice Act (1997), to ensure the safety and security of the Centre.

(g) **Were decisions about detainees being unit bound reviewed and, if so, how often were such decisions reviewed?**

This was reviewed at the CST meeting (Mondays) and the MDT meeting (Thursdays) and any Interim CST meeting that may be held between these

meetings.

(h) **Did you have any concerns or were you made aware of any concerns about the placement of detainees or detainees being unit bound?**

My concerns regarding "unit bound" practices and 'Blue colour 'Practices were the same- that the program of support when the program was first introduced was inadequate and did not provide any level of therapeutic intervention for young people and needed to be completely reviewed for content, mode of delivery, and individualised to meet the needs of young people.

(i) **If so, what were those concerns and how did you act on them?**

As described in point 38 when I was made fully aware of the content and structure of the Blue program / unit bound program from the discussion with [redacted] and an email from [redacted] on 12 March 2019 (attachment 13). [redacted] described a young person behaviour not improving while they were on this program. I considered the program highly unsuitable for a young person who was displaying highly aggressive/ violent and dysregulated behaviour. Whilst in the short term the security and safety risk of the Centre needed to be addressed, the content and delivery of the program was not trauma informed, developmentally appropriate, or designed to meet the needs of the cohort of young people in the Centre.

It contained PowerPoint reading presentations that were delivered to the young people with youth worker staff, but there was no record or accountability of the delivery. I considered the content format and the delivery by untrained staff was not suitable as a therapeutic program to meet the needs of the young person. I sent an email to Patrick Ryan on 18 March 2019 (attachment 14) describing the program as inappropriate as it was "cognitive heavy". It required high levels on literacy skills- something the young people in detention don't have, as well as high cognitive skills, and advanced levels of reflective functioning. Many young people in detention have cognitive disability, low cognitive capacity, or learning disabilities. It was not based on any contemporary trauma informed approaches informed by evidence. And there was no rigor to the program or evidence that it worked.

My actions were to quickly develop an individualised support program that would meet the needs of the young people who were dysregulated. I collaborated with the PS&P team, the school staff, the psychologist and the youth workers to develop an individualised program for young people on Blue colour or Unit bound that was trauma informed, based on the neurobiology of trauma, use trauma informed approaches recommended by the Australian Childhood Foundation.

Intensive individualised programs were developed by the PS&P team and delivered as a 1:1 program with the staff described above.

I commenced drafting a proposal for the Blue colour that incorporated these principles of trauma informed care, delivered at training I attended with some other AYDC staff by the Australian Childhood foundation, called " Holding

Firm".

The principles of this can be found in the PowerPoint of the training (attachment 10). Based on these principles, I advised at the BDS review meeting on 12 June that the Blue colour needed review and further work, and suggested forming a working group to develop this program to better meet the needs of young people according to these principles. This is the minutes of the BDS meeting which is in annexure H)

54. **Was there a formal or informal policy of using placement decisions or threats of placement decisions as a means to influence or punish the conduct of detainees?**

Not that I am aware of.

55. **Was there any policy or practice of using the behaviour or potential behaviour of some detainees as a threat to influence or punish the conduct of other detainees? For instance, was there ever a policy or practice of threatening detainees with the risk of placement in the Franklin Unit and/or the risk of being placed with detainees who posed a risk of physical or sexual harm to them?**

I remember on occasion I would hear a comment by a youth worker or member of the CST that placing certain detainees with other detainees was helpful to manage the behaviour of detainees, but when I was present the Chair of CST [redacted] would respond this was not appropriate, or the general consensus of the CST group would not support this.

I consider that the decision referred to in Annexure J, related to the placement of Max [redacted] in the Franklin unit may have been made on this basis. Some staff found Max [redacted] difficult to manage, and I am aware some staff did not like Max [redacted]. Max [redacted] had a know history of vulnerability to sexualised behaviour/ sexual assault, and the fact he was placed in a unit with two detainees who had been observed to use sexualised behaviour was completely inappropriate.

Isolation

56. **The Commission has received evidence suggesting the inappropriate use of isolation of detainees.**

(a) **What is the difference between a detainee being in isolation and a detainee being unit bound?**

My role was not involved in decisions regarding the use of isolation, nor were any of the staff I supervised required to use the Isolation procedure in the Centre. For that reason, I am aware of the policy of "use of Isolation" but am not able to comment on the application of the policy in practice. I am aware the use of Isolation is guided by policy, and had some strict paraments when in use- such as frequent observation, and use should be for a minimal time

My understanding of use of Isolation was informed by the Youth Justice Act (1997) that is used as a last resort, when all other approaches have failed, to ensure the safety and security of the detainee, other detainees, and the Centre. It is used for the shortest time possible, and the person in isolation must be observed every 15 minutes, and the period of isolation recorded, and a register kept on the use of isolation. The Isolation is to confine a detainee to one room with no other people in the room. This is different to "unit bound" as Unit bound was not confined to a room, but rather was about limiting the movement of a young person to be within the unit area, to ensure the safety of the Centre. The detainee still can have contact with other staff, residents, as well as access other areas of the Centre in a supervised manner but they are not participating in the usual full routine of the Centre and would have school programs and other programs delivered in the unit.

(b) **Did you have any concerns or were you made aware of any concerns about the use of isolation or detainees being unit bound?**

Yes, at times

(c) **If so, what were those concerns and how did you act on them?**

At one time I was made aware by a staff member in my team that a young person was put in isolation, and the staff member considered it inappropriate and that it did not follow the approved procedure. I spoke to the manager of the staff member responsible and asked them to look into this. I checked in with the detainee and advised them of how they can lodge a formal complaint.

I was often concerned at the use of "unit bound" when this practice extended beyond a few days, as this was not good for the wellbeing of a detainee. On every occasion that this occurred, I advocated at CST or MDT for programming to consider how the young person could be supported to participate in the full Centre activities. Actions I took would also include having the young person on the MDT agenda for the MDT team to identify programming and strategies to support a young person to reintegrate to the usual Centre activities.

Another action I took was to complete a referral to QIWD unit in CYS for a SQPA consultation. This referral was for the purpose of staff learning about the likely cause of the behaviour/ challenges, and to identify strategies and skills to work with the detainees to support them to integrate into usual programming. The SQPA used a "Signs of Safety" and "appreciate Inquiry" approach to do this. This is a practice used for facilitating complex case discussion and work. I leant to facilitate these sessions myself, and so at other times I chaired and facilitated meetings of "Signs of Safety" mappings, to identify with a multidisciplinary group what the concerns for safety were, and what strengths of the detainees, and what actions would support them to rejoin Centre programming. This was often very successful to support

young people to return to the full Centre programming.

Searching

57. **The Commission has received evidence suggesting the inappropriate use of strip searching, both as to when searches were carried out and how they were carried out.**

(a) **What role (if any) did you have in reviewing the use of strip searches or advising Officials on when and how strip searching could be used?**

I was not involved in this review

(b) **Did you ever have, or were you made aware of, concerns about the use of strip searching?**

No

(c) **If so, what were those concerns and what if any action did you take?**

58. **The Commission is aware that a new policy on searches was issued in or around September 2019.**

(a) **What role (if any) did you have in the formulation, distribution and training related to that new policy?**

I was not involved in this process. [redacted] was overseeing all changes to policies and procedures in the Centre at this time. I was not involved in any part of this change.

(b) **What were the changes that were made?**

I cannot recall the changes that were made in September 2019. It was not part of my role to conduct strip searches, nor was it the role of any staff in my team who reported to me. As I was on leave from the 16 September 2019 until13 October 2019, and I finished working at AYDC after this date I was not familiar with the changes made.

Staffing and Workplace

59. **During the course of your work at Ashley Youth Detention Centre did you ever feel unsafe at work? If yes, provide details.**

During the course of my work I did not often feel physically unsafe at work. I was in a role that was not direct supervision of detainees, or operational staff. When I had contact I would follow policy and check if it was safe, before being in direct contact with detainees. I never felt physically unsafe with detainees or with any officials.

I did not feel psychologically safe at work. I felt there was an ever present mistrust between officials/ staff from different work areas towards others, and

in meetings I observed some "bullying" type behaviour- such as speaking loudly over people, eye rolling by officials, sighing etc. To my knowledge this was never addressed by the chair of meetings, or the managers of these staff, so the behaviour continued. I have never before in other workplaces observed this behaviour to the level and extent it occurred in AYDC. I did speak to the Centre Manager, Patrick Ryan about this at the time.

I also started to feel increasingly psychologically unsafe working with my direct line manager, Patrick Ryan. This occurred in the last 4-5 months of working at AYDC (from June-October 2019). I noticed I was not included in some information, discussions and meetings. As well I became increasingly aware of differences in treatment I experienced compared to other managers. I felt unable to perform my job to my full capacity, as I no longer felt safe in discussing difficult issues or practices when this may be of a different opinion or be cause for a potential conflict.

The action I took in this situation:

I spoke to the South Youth Justice area manager [redacted] for advice as I had a professional relationship with [redacted] from past work project we had collaborated on. (see attachments 15 , attachment 16) . On [redacted]'s advice I spoke to the Youth Justice Director, [redacted] about this, and requested a different line manager. [redacted] gave me some advice in how I may be able to manage this, which I followed, by meeting with Patrick to discuss my concerns and feedback [redacted] advised me to give to Patrick. However this did not resolve the issues, and in fact the behaviour from Patrick escalated – Patrick became very argumentative, and I observed him using dismissing, gaslighting and stonewalling behaviours. When I said I would have another person at any future meetings Patrick told me I had no right to this, and yelled at me when I left the meeting words to the effect of "when you can't win an argument you walk away". I reported this to [redacted] (see attachment 17). [redacted] advised me he would follow this up. However, [redacted] resigned soon after this, so I felt I had no other senior managers for support in my role.

I also sought EAP support, and visited my GP, took a short period of leave, and applied for other positions, and left AYDC soon after.

60. **During the course of your work at Ashley Youth Detention Centre did you ever become aware that any other Official felt unsafe at work? If yes, provide details.**

No

61. **Have you ever been engaged in, or injured by, a physical confrontation with a detainee? If yes, provide details.**

No

62. **Did you ever witness an incident in which an Ashley Youth Detention Centre Official was engaged in, or injured by, a physical confrontation with**

a detainee? If yes, provide details.

No

63. **Have you ever been engaged in, or injured by, a physical confrontation with another Official? If yes, provide details.**

No

64. **Did you ever witness an incident in which an Official was engaged in, or injured by, a physical confrontation with another Official? If yes, provide details.**

No

Contacting Police

65. **In your view did a determination that a detainee had engaged in conduct which amounted to a Detention Offence require that police be notified? Please explain your answer and in particular the characteristics of detainee conduct (whether constituting a Detention Offence or not) that would, in your view, require police to be notified.**

- It is not a requirement under the Youth Justice Act, but when a Detention Offence is also defined under the Criminal Code, in retrospect, perhaps they should be notified to Police.
- Any assault behaviour should be notified to police (e.g. physical or sexual assault, as well as serious verbal abuse or threats that could indicate threat to harm someone.
- I think an MOU with police on this matter and a policy should be developed to guide staff.

66. **Was there a policy or procedure that guided decisions as to whether police should be notified in response to conduct by Officials or detainees?**

Not that I am aware of

67. **Where a decision was made to notify police, who was responsible for making the notification and coordinating or facilitating any investigation or attendance at Ashley Youth Detention Centre by police?**

This was not clear and left to the determination of the individual. Certainly, the Centre Manager never advised me to contact Police or the Child Safety Service. When I advised the Centre Manager that notifications should be made, he did not support this, and having a policing background, I assumed he would hold this knowledge and authority on the responsibility of this.

68. **Did you ever notify police yourself of any concern or allegation arising from the conduct of a detainee? If so, what was the outcome of your notification?**

No I did not. I advised CSS to contact the police on my behalf.

I advised a staff member, [redacted] who was a member of my team, to contact the police when she was made aware of a potential offence by a detainee that the detainee mentioned to her that occurred in the community prior to his detention. I cannot remember the outcome.

69. **In the period you worked at Ashley Youth Detention Centre, were there any occasions when police were turned away at the gate or otherwise discouraged or prevented from entering Ashley Youth Detention Centre? If so please detail those occasions and the reasons why police access was not enabled.**

Not that I know of.

Conduct of other Officials: Sexual misconduct

70. **Did you ever witness an Official engage in any form of sexual or sexually suggestive behaviour (including the use of sexually suggestive language) towards detainees? If yes, provide details.**

No.

71. **Did you take any action in response to what you witnessed? If yes, provide details of the action you took. If no, explain why you took no action.**

N/A

72. **Did you ever receive reports or information from detainees or other Officials about Officials engaging in any form of sexual or sexually suggestive behaviour towards detainees? If yes, provide details.**

No

73. **Did you take any action in response to what was reported to you? If yes, provide details of the action you took. If no, explain why you took no action.**

N/A

74. **What do you understand the obligations are in relation to mandatory reporting as an Official at Ashley Youth Detention Centre? In your view, was there a clear understanding among Officials at Ashley Youth Detention Centre of their obligations as mandatory reporters?**

I understood that as an official working at AYDC, my obligations are the same as any state servant, and also as a Registered Nurse, I am a mandatory reporter. This means if I am aware of any risks to the safety and wellbeing of children or young people, I am mandated to notify the Child Safety Service of these concerns.

I do not believe that officials in AYDC were clear on these obligations. When I

first started working at AYDC I was made aware of a young person making threats about how they would treat their partner in the community. I advised the Operations coordinator and Operations manager that the police need to be notified and the Child Safety Service. I advised the senior management group that all staff need to be educated/ trained in their obligations as mandatory reporters. I was told that staff were already trained in this.

Conduct of other Officials: Other forms of misconduct

75. **Did you ever witness behaviour by an Official towards detainees which you thought was inappropriate, either because it was in breach of a policy or because you, personally, felt that it was unfair, unjust, uncalled for or otherwise inappropriate, in circumstances involving the:**

(a) **use of isolation facilities by an Official in relation to a detainee;**

No

(b) **personal search of a detainee by the Official;**

No

(c) **use of force by the Official against a detainee;**

No

(d) **nature of an interaction between an Official with a detainee more generally;**

Yes, on occasion I witnessed some staff speak with disrespect to a detainee; On each occasion I spoke with the staff members manager to ask them to follow this up. I also would pass this observation on to the Centre manager, of any staff behaviour I observed to be not appropriate.

(e) **control by an Official of a detainee's access to visitors (for example, family, friends, legal representatives, external oversight)?**

I did not witness this, but I was made aware on instances of this, and responded as per point 77(e)

76. **Did you take any action in response to what you witnessed? If yes, provide details of the action you took. If no, explain why you took no action.**

As mentioned in point 76(d) on occasion I witnessed some staff speak with disrespect to a detainee and on each occasion I spoke with the staff members manager to ask them to follow this up. I also would pass any observation of staff behaviour I observed to be not appropriate to the Centre manager, When necessary, I would advise a detainee of their rights to make complaints about how they were treated to the Centre manager, the Ombudsman, and/or the Commissioner for Children.

77. **Did you ever receive reports or information from detainees or other Officials about behaviour by an Official towards detainees which they or you thought was inappropriate, either because it was in breach of a policy**

or because they or you, personally, felt that it was unfair, unjust, uncalled for or otherwise inappropriate, in circumstances involving the:

(a) **use of isolation facilities by an Official in relation to a detainee;**

No

(b) **personal search of a detainee by the Official;**

No

(c) **use of force by the Official against a detainee;**

No

(d) **nature of an interaction between an Official with a detainee more generally, or;**

Yes- on occasion I had reports from staff in my team about interactions they observed that could be described as disrespectful to a detainee. I would always follow this up by speaking to the staff members manager and the Centre Manager.

(e) **control by an Official of a detainee's access to visitors (for example, family, friends, legal representatives, external oversight)?**

Yes. I observed and was made aware of young people being denied access to visitors from family members, as well as from service/ support organisations. In particular I noted this on two occasions for aboriginal young people. On both occasions I raised this with the Centre Manager that this is a breach or the rights of the young people.

On the first occasion it was a decision made by the CST group to refuse a visit of the brother of an aboriginal young person in detention. No valid rationale was given, and the decision did not align with any policy (see attachment 18). I appealed this decision and explained the visitor policy does not support the decision that was made (see attachment 19)

The second occasion a visit was refused by Tasmanian Aboriginal Centre Staff to an aboriginal young person. The visit was particularly important as the purpose was for a young person to view the funeral video of their recently deceased father with a respected aboriginal mentor from the Tasmanian Aboriginal Centre (TAC). The decision was made by an Operations Coordinator to refuse the visit at the time of the visit. The TAC staff was refused entry at the gate, despite the visit being an approved visit and organised by the PS&P team. The PS&P team also offered the operational coordinator to provide staff to supervise the visit, to ensure the operational safety needs of the Centre could be met. However, the visit was refused by the Operational Coordinator, in consultation with the Centre Manager, with no valid reason provided. I communicated this with Centre Manager Patrick Ryan by email asking this be addressed. (see attachment 20)

If yes, provide details.

78. **Did you take any action in response to what was reported to you? If yes, provide details of the actions you took. If no, explain why you took no action.**

On the first occasion above I appealed the decisions on the first occasion, and had approval for the visit to occur the following week detailed in attachment 19)

On the second occasion I communicated this with Patrick Ryan as Centre Manager and explained this is a breach of rights, as well as not prioritising the needs of young people for support from services. I asked this be followed up by Patrick. However, it was passed to the Operations manager ([redacted]) to follow up (see attachment 20)

I was not happy with this outcome, as the visit was canceled with Patrick's approval by an Ops Coordinator. Given it was the Centre manager who gave the approval to cancel the visit, I would have expected that the Centre manager would have spoken to staff about the importance of working with all staff in the Centre to follow the visit procedure to ensure visitors can be supported to be in the Centre. I would expect the Centre manager to support young people's connection to family, and in particular, when this is organised to support the needs of a young Aboriginal person whose father had recently passed away, and the visit was arranged for an aboriginal mentor to sit with him to view his father funeral recording. I considered this insensitive and a violation of a young aboriginal persons rights.

79. **Did you ever witness behaviour by an Official towards another Official which you thought was inappropriate, either because it was in breach of policies on appropriate behaviour in the workplace or because you, personally, felt that it was unfair, unjust, uncalled for or otherwise inappropriate? If yes, provide details.**

When I commenced working at AYDC I observed many instances of disrespectful emails sent to large group of staff.

I did not witness any other behaviour of concern by officials in my time there.

80. **Did you take any action in response to what you witnessed? If yes, provide details of the actions you took. If no, explain why you took no action.**

I took action by advising the Centre manager my opinion that I thought this practice of staff members sending inflammatory emails to large groups of staff needed to stop, and advised that it was damaging for relationships within the Centre, and contributed to a poor Centre culture. I advised my team not to respond to these inflammatory emails, and not to send any inflammatory emails. I observed that this was effective in stopping these emails to a large degree.

81. **Did you ever receive reports or information from other Officials or from detainees about behaviour by an Official towards another Official which**

they or you thought was inappropriate, either because it was in breach of policies on appropriate behaviour in the workplace or because they or you, personally, felt that it was unfair, unjust, uncalled for or otherwise inappropriate? If yes, provide details.

Yes- I was on occasional advised of disrespectful behaviour by a member of my team- I spoke to the staff member about this.

On another occasion I was advised by a staff member in my team of disrespectful / bullying type and passive aggressive behaviour towards them by another manager- I spoke to the manager about this and explained what I expected in the future. The manager was remorseful, apologized to my staff, and it did not occur again.

82. **Did you take any action in response to what was reported to you? If yes, provide details of the actions you took. If no, explain why you took no action.**

Yes- as described above. I believe most staff working at AYDC at the time were motivated to do the right thing, but that the leadership did not always set the expectations of behaviour, nor follow up with staff on issues as required to ensure issues were resolved and standards of behaviour were enforced and maintained.

Management of concerning behaviour by detainees

83. **In your experience, did Officials at the Ashley Youth Detention Centre have sufficient training, skills and resources to respond to and manage the full spectrum of behaviours exhibited by detainees, including concerning or harmful sexual behaviours?**

- No, absolutely not. When sexaulised behaviour was discussed at the CST related to the incident described in Annexure I, the staff in the CST meeting described this a "locker room" behaviour and dismissed it as not a serious issue.

- Leadership staff of the Operations team and the Centre Manager and many youth workers appeared to have no knowledge of what constitutes problem sexual behaviour, or how to respond. Nor did staff appear to know what is normal sexual behaviour for adolescent young people.

- Some operational staff appeared to have very little ability to apply the training they have done regarding trauma and trauma behaviour to the practice setting.

- Some operational staff appeared to have very little knowledge or understanding of the effect cognitive disability has on a young person's behaviour, and little knowledge or skills in working with people with cognitive disabilities.

- However, I did observe some staff (youth workers) to have excellent

interpersonal skills working with young people. These staff were kind, compassionate and endeavored to understand the needs of the young people, and very receptive to learning. However, they were not adequately provided with high quality education and training or resources such as practice guides. Nor were they supported by an operational management team with high level skills and knowledge to support them to use these skills and knowledge in practice.

84. **Were there detainees whose level of risk to Officials or other detainees could not be satisfactorily managed by Officials at Ashley Youth Detention Centre? If so, what actions or options were available to Officials in relation to such detainees? Please provide details of any instances were such actions or options were considered or taken.**

Yes there were detainees that at times presented a high risk to officials and other detainees in the Centre, that could not be adequately managed.

At the time I worked at AYDC there was a process for these detainees to be considered for transfer to Risdon Prison. This occurred through the Transfer Assessment Panel – a panel meeting of AYDC managers and Risdon prison staff, where transfers were considered and discussed. This process was used on a number of occasions whilst I worked at AYDC. I am not aware of a policy or procedure or Terms of reference that guide this process. I observed two TAP meetings in my time at AYDC, that appeared to be more of an informal discussion that a meeting with rigor. I was not involved in the decision making about the transfers, and my understanding is that transfers of detainees to Risdon Prison required final approval and facilitation by the Detention Centre manager and the Risdon Prison manager.

Incident involving Margaret

85. **The Commission is aware of a sexual incident involving** Margaret **in around** [redacted] **2019. Please review the attached CARDI Conversation Summary Report, dated** [redacted] **2019 (Annexure D: TDCT.0004.0009.0158), the attached email from** [redacted] **to** [redacted]**, copied to yourself, dated** [redacted] **2019 (Annexure E: DCT.0004.0002.8639) and the attached MDT meeting minutes dated** [redacted] **2019 (Annexure F: DCT.0004.0002.8892):**

(a) **Do you consider that the MDT and the Centre responded appropriately to concerns arising from the incident?**

No I do not think the response was adequate at all. My first comment is that I was not made aware of the incident at the time and did not become aware of the incident until [redacted] 2019. I am still unsure exactly what date the incident occurred. I did not see an incident report, and the incident report was not tabled at the CST meeting on Monday [redacted] 2019 see minutes (attachment 21), or on Tuesday [redacted] 2019 see minutes (attachment 22) as per the standard procedure. Note that on Monday [redacted] CST meetings minutes it is recorded that an incident was resolved prior to the CST meeting. This is outside of standard practice, and I did not notice it in the minutes at the time. Regardless, I was not aware of the incident from the usual process of the incident

being discussed at the CST meeting. I was not aware of this being included in the meeting minutes documentation at the time.

I became aware of the incident for the first time when returning to work on Tuesday [redacted] (as I worked .7FTE, Friday [redacted] was a day off for me, and [redacted]. I was made aware of the incident by a staff member in my team, Conferencing Convenor [redacted], on Tuesday [redacted]. [redacted] had sent an email on Friday [redacted] 2019 (attachment 23) to me, asking the question why no one in the case management team (PS&P team) had not been consulted about both the decision of unit detainees unit placement (particularly the risks putting a vulnerable female in with other males detainees) which could have prevented the incident, but also the appropriate response following the incident. These decisions were all made initially only by operational staff, and without any consultation with the PS&P team, and without psychologist input.

On Friday [redacted] sent an email to Chester [redacted] and myself that the incident should be reported to the CSS, and also advise Community Youth Justice staff. (see attachment 24). Chester [redacted] forwarded this email to Patrick Ryan, and Patrick Ryan responded to [redacted], Chester [redacted] and myself (on the same date) that communication was to go through him to the director regarding the incident, and "no other member of staff is required to action any correspondence".(see attachment 24). For reasons mentioned regarding my leave, I did not see this email until Tuesday [redacted] 2019.

Friday [redacted] at 2:48 pm [redacted] emailed to Patrick Ryan and myself that CSS/ CYJ and Marg[redacted]s parents need to be notified, and she would do this. Patrick responded this as valid, and investigation continues and that I would be briefed on Monday (see attachment 25 Marg[redacted] incident [redacted] 2019)

I was never briefed by Patrick Ryan on the incident. I was advised by [redacted] when I arrived at work on Tuesday [redacted] 2019. I spoke to Patrick Ryan in person and question why I was not made aware of the incident, and why neither the PS&P team nor psychologist were not consulted when considering how to respond to support Marg[redacted] after the incident. I do not remember his response. I told him I thought it was a cover-up, that the incident had not been document or discussed at any of the correct forums, or involved the PS&P team, and that this has potentially created harm for the young people involved. I arranged for the psychologist and staff in my team [redacted] to see Marg[redacted] and provide her with support. I asked both [redacted] and [redacted] to advise me if the incident was consensual sexual behaviour or not consensual. Both [redacted] and [redacted] advised me Marg[redacted] had told them it was consensual.

I was not present for the MDT meeting on [redacted] 2019. I believe that the significance of the incidence warranted much more documentation than was recorded in the minutes of the MDT. The minutes should have

included reference to the full MDT discussion of Marg's wellbeing, recommendations of care and any actions required. If this wasn't discussed by the MDT and a plan of care or review of care done, then this is also a poor response.

(b) **Should police have been notified in relation to that incident?**

As the incident at the time was described by the young people involved as consensual, I did not think the police needed to be notified. Both young people were within an age that they can consent to sexual activity with another minor of similar age, which they were, and sexual activity of this type that is consensual would be considered within normal sexual behaviour. I considered that CSS should be notified, as both children were place in a compromising situation to their wellbeing when under the care of the Detention Centre, and I considered that the CSS would then be best place to advise if a police notification should be made. I thought the parents must be notified, as the children guardians.

(c) **Do you consider the incident was sufficiently and appropriately investigated, having regard to Margaret 's vulnerabilities?**

No I don't not believe the incident was sufficiently investigated with regard to Marg's vulnerabilities. I did not ever hear of any level of investigation that occurred by the Centre to the incident. I felt like the incident was covered up initially, and then not properly addressed at the time. I received no feedback on any investigation that was done. The communication in the email from Patrick Ryan stated he would be following the incident and would brief me. (attachment 25).

The CSS full record for Marg was not made available to staff supporting Marg in AYDC. Now that I am aware of the CSS record of Marg (which is not made available to staff outside of the CSS) I consider that some advice from the CSS could have supported staff to be better informed to support Marg. I think that some further policy work to guide a best practice approach for staff working in AYDC with the CSS could help provide better support to young people in detention who are at risk.

(d) **Do you consider that the incident and the response was appropriately documented in accordance with applicable policies?**

No I do not. I never saw the incident report on this incident. It was not tabled at any CST meeting as per the usual procedure. I cannot comment on the extent of the reporting, as I did not see any reporting on this.

(e) **What are your reflections on what could have been done better or differently to protect Margaret ?**

Marg should never have been placed in a unit with other male detainees in what was not an approved process, by what was described as an "after hours program". Prior to this incident, I had never heard of the practice of an "after hours program", and there is no policy or procedure for this practice. This decision was made by an Operations

Coordinator and the Centre Manager alone, without input from the PS&P (Case management team) or any other staff who would be able to provide advice (e.g. psychologist/ health staff). This is why decisions and advice from the MDT group should be included in operational decision making. I also question what level of supervision was provided by the operational staff in this situation, for this incident to occur. I would appear it was inadequate. If staff had been in constant supervision of the young people the likelihood of this occurring is very low.

When reviewing the Cardi Conversation (annexure D) with the full child safety history of notification for Marg- this highlights her vulnerability. This was not known to me at the time, as it is not information shared at the time to AYDC. However, as I have significant experience working with adolescent girls who have experienced trauma, I would assume that they would be vulnerable, and this was why I had significant concerns regarding how this was managed, which I advised Patrick Ryan in person.

86. **Please review the attached email exchange between yourself and Patrick Ryan, dated [redacted] 2019, regarding an incident that occurred in [redacted] 2019 (Annexure G: DCT.0004.0003.3240):**

(a) **What steps (if any) were taken in response to the concerns raised by you in relation to the seriousness of the incident in question and the inadequacy of the MDT minutes?**

I was not made aware of any steps taken in response to my email, apart from what Patrick Ryan stated in the email he would do. I did not ever receive a copy of amended minutes to include more detail, as this was what I was seeking. The detail of the minutes of MDT was for the purpose of informing care and support for Marg by staff in the Centre. It is the responsibility of the MDT Chair to ensure the minutes are a factual and accurate record of the discussion. The level of information in these minutes I consider completely inadequate for providing a summary of concerns and actions to support the care and wellbeing of Marg.

Management of Albert [redacted] and Finn [redacted]

87. **The Commission is aware of concerns being expressed by you during 2019 about the management of detainees Albert [redacted] and Finn [redacted], including with regard to their placements, ranking on the behaviour management system, whether there were appropriate therapeutic interventions in place for them, and whether they posed a risk to other detainees, including a risk of harmful sexual behaviours.**

88. **Please review the attached BDS Review Committee Meeting Minutes, dated [redacted] 20192 (Annexure H: DCT.0004.0003.5819):**

(a) **What, in your view, were the benefits and weaknesses of a blue system?**

The benefits of the Blue System is that the Blue program may provide safety and security for the young person and the staff and other young people in the Centre, when on occasion young people with significant trauma behaviours who use violence can place themselves, other young people and staff at risk. The Blue system restricts the young persons access to other young people, as well as provides intensive supervision by youth workers, and restricts their access to areas of the Centre that have high levels of security (e.g. secure units), so reduces security risks.

The weakness of the Blue system I detailed in an email to Patrick Ryan on 16 March 2019 (attachment 14) just after it had been introduced. I reviewed the content and structure of the Blue program and identified it was not trauma informed, and was very unsuitable in content and delivery method. It required high levels of literacy and cognitive ability, as well as high levels of reflective functioning, which are all things not usually present in young people who have experienced trauma, and displaying trauma-based behaviours.

I also noted an absence of rigor in how it was delivered, and also question who was delivering the program, and where the staff delivering the program appropriately trained and skilled to do this. This is why I recommended the program undergo a robust review, with a view to developing a more trauma informed program of therapeutic support to young people who are requiring this level of intervention.

(b) **At this time, was an appropriate program in place for Albert [redacted] and Finn [redacted]?**

I am unsure what Program was in place for Albert [redacted] and Finn [redacted]. It would depend on what was occurring at the time regarding their behaviour in the month of [redacted].

89. **Please review the attached email exchange between yourself and Patrick Ryan between [redacted] 2019, and the email from yourself to [redacted], Hugh [redacted], Louisa [redacted], Chester [redacted], Patrick Ryan, copied to [redacted], dated [redacted] 2019 (Annexure I: DCT.0004.0005.2623):**

(a) **What steps (if any) were taken in relation to the matters set out in the email dated [redacted] 2019 by people other than you?**

[redacted] (Conference Convener) emailed me on [redacted] 2019 (attachment 26) to advise that she had watched the video footage and agreed with the decision that a Child Safety Notification was require, and as such, the conference process will not continue until [redacted] was aware of the outcome of the CSS response, and any police response is completed.

No other steps were taken that I am aware of by any other staff in the email group. I was not advised by anyone else in the email that any

action had been taken by them.

You will note in annexure I, on Wednesday [redacted] Patrick Ryan replied that this was "…reviewed at CST on Monday. There are varying views on levels of seriousness of the matters, but actions to come from it include the expedite of Conference for [redacted] and [redacted]…".

The suggestion for this action, and advice by Patrick Ryan that Conferencing was to occur, was not appropriate. The Conference Convener ([redacted]) is the person to assess and determine if a matter is suitable for Conferencing. [redacted] in this instance reviewed the video footage of the incident, and determined this required further investigation by CSS/ Police before possible to progress to Conferencing. (attachment 26). This is because under the principles of restorative practice that Conferencing occurs, the Conference needs to ensure neither the victim or perpetrator is not harmed in the process. This cannot be ensured until after an investigation of the incident by police and CSS. An outcome of this investigation may be that the incident was not appropriate for the Conferencing process.

90. **Please review the attached email from yourself to [redacted] and Patrick Ryan, dated [redacted] 2019 (Annexure J: DCT.0004.0016.3354 at 3355):**

(a) **In your view, what were the appropriate steps that should have been taken in response to the matters raised in this email?**

The steps taken by [redacted] as Operations manager were appropriate to his role, as he immediately recognised this risk, and moved [redacted] to another unit.

The steps taken by the Centre Manager, Patrick Ryan, should have been to immediately prioritise a review of the policy/ procedure used to guide movement/ transfers of detainees between units. This review would be for the purpose of identifying improvements that can be made to the policy and process, to ensure decisions made in the future regarding unit moves were made in the best interest of the detainee, and ensure that safety and wellbeing of detainees at all times.

(b) **To the extent that the steps taken were not appropriate, why do you think the appropriate steps were not taken?**

I am unsure. Taking the steps to identify risks and improve policies and processes is an essential part of quality improvement cycle in health and human service, and should also align with the "continuous improvement program" that was implemented in AYDC in 2017, and referred to at point 14 in Annexure C. I am unsure why this would not be followed up by the Centre Manager.

91. **Please review the attached email from yourself to Patrick Ryan, dated [redacted]**

[redacted] **2019 (Annexure K: DCT.0004.0004.7755):**

(a) **What steps (if any) did you take in relation to your question about the pursuit of education and training for Officials around sexualised behaviours of detainees?**

This email in Annexure K was a follow up email to an earlier email I had sent on the same day.

The email in Annexure K was sent on [redacted] at 12:14 pm (contained in Annexure K) to Patrick Ryan to inform him of information from the forensic psychologist employed at AYDC at the time ([redacted]) that provided definitions and web links to further information descriptors of what constitutes sexual abuse and problem sexualised behaviour, and explained that AYDC staff needed training in this area, and I was requesting this be pursued by Patrick Ryan, as the Centre Manager.

On [redacted] 2019 at 10:48 am I emailed Patrick Ryan (contained in Annexure I) asking the question if he had progressed arrangements for training from the Sexual Assault Support Service (SASS) he had mentioned when I first started working at the Centre, that had never occurred. (contained in Annexure I)

> *"I remember you were looking into some staff training from SASS when I first started- I wonder if this is something that can be followed up for staff?*
>
> *Some education for staff to help them to identify problem behaviour according to what is defined as a problem, and also have some skills in responding early, so residents are taught what is appropriate. This keeps the residents safe who has the behaviour, as well as other residents in the centre."*

The response from Patrick Ryan was vague- and referred to other people following up, there was no commitment to actions to be taken to address this. My role at AYDC was not to organise staff training. I had no oversight or management of staff training. This was the responsibility of the Centre Manager and the Training Coordinator. I did not have any authority to arrange staff training for the Operational staff of AYDC.

As I did not get a commitment from Patrick Ryan that he would organise the training for staff with the Training Coordinator, I then sent the email in Annexure L, on [redacted], to [redacted] (Training Coordinator) and [redacted] (Director) , and CC Patrick Ryan, requesting it be arranged that staff at AYDC attend some training that was available through Berry Street. The training titled " Working with Young people over 12-years with problem sexual behaviors" was to be delivered in Launceston in the near future. In this email I explained the rationale for the training need, and also suggested this be added to

Youth worker training program, with a rationale. I received no response from [redacted], [redacted] or Patrick Ryan to this request.

I requested staff be trained in three separate emails to three senior staff members who were either responsible for staff training or had oversight of staff training. I provided a suggestion of a suitable training course and provider. As I was not responsible for staff training, and not had oversight of this as part of my role, I believe I made every effort to follow this up within my influence and time working at the Centre.

I was on leave from [redacted] 2019 until [redacted] 2019, and finished working at AYDC on [redacted] 2019, so had limited opportunity to further follow this up. However, I did provide this information on training needs in an email to the newly appointed Clinical Practice Consultant Alysha [redacted], to pursue this as an area for practice improvement.

(b) **Are you aware of what steps (if any) other Officials took in response to the matters raised in this email?**

I am not aware of any steps or actions other officials took in response to this email I was not advised of any.

92. **Please review the attached email from yourself to [redacted] and [redacted], copied to Patrick Ryan, dated [redacted] 2019 (Annexure L: DCT.0004.0016.3350):**

(a) **What response did you receive to this email?**

I did not receive a response to the email.

(b) **Was your suggestion that Officials at Ashley Youth Detention Centre be supported to attend the training you recommended accepted and/ or acted upon? If so, provide details. If not, why not?**

Not that I am aware of. I did not receive any communication regarding the training, and was not advised that any staff were supported to attend the training.

I am not sure why I did not receive a response.

(c) **Why did you consider it important for Officials at Ashley Youth Detention Centre to attend the training?**

I considered this important because in my observations and interactions with staff and communication with the Centre Manager, the Operations Manager, Operations Coordinators, and youth workers it was apparent that there was not an awareness of the definition of problem sexaulised behaviour, nor was there any apparent knowledge and skills by the staff in addressing this. Of particular concern to me was that staff in leadership positions were not aware of this and this had created a situation of sexual abuse in the Centre, and would create more risk for young people in the future if this was not addressed.

[2] Note, the document title and related documents (correctly) identifies the meeting date as [redacted] 2019 for these minutes, however within the document the minutes are (incorrectly) dated [redacted] 2019.

93. **In light of the various documents referred to above:**

(a) **Did you have concerns about the way in which the concerns expressed by you were responded to by the CST and by Ashley Youth Detention Centre management?**

Yes, I had significant concerns. I have significant concerns that the email I sent was ignored/ not responded to by anyone in the email group of members of CST and the Centre Manager, and the response I received was only when I asked for a response form the Centre Manager after seven days. The response was this had been reviewed- however I was not informed of the outcome. The response from the Centre Manager to such a serious incident I believed was dismissive and not appropriate- it referred to varying views, and that poster information would be put up on a notice board. In no way does poster information change or improve practices of such serious safety and wellbeing risks to young people. I had serious concerns that no CST members, nor the Centre Manager believed that this required notification to Child Safety service as mandatory reporters, nor was there any awareness of the need to notify police. Given these were all managers with significant experience in working with vulnerable young people, with significant background experience in detention settings and policing, this was a significant concern for me to be working with a management team that did not respond to such significant practice issue.

(b) **Do you consider that Albert [redacted] and Finn [redacted] were managed appropriately with regard to their own needs and to the risk they posed to others?**

No I do not believe they were managed according to their own needs. I stated this in the email of Annexure I (the email dated [redacted] 2019). I stated they required a program of education/ psychological support to address the behaviours, so they were able to learn appropriate boundaries and respectful behaviour to others. Not addressing this placed them at risk for being perpetrators of future sexual assault. AYDC had a responsibility for rehabilitation for the detainees, and this was not addressed. This was my intention of the statement in my email regarding Albert and Finn 's needs.

I also do not believe they were managed appropriately in regards to the safety risk they posed to other young people in the Centre. It would have been appropriate they were put on 1:1 supervision (also called Very Close Supervision or VCS).

VCS was used to ensure the safety of residents in the Centre from

another resident. This practice assigned a youth worker to work directly with a young person 1:1, stay within a limited distance, and be able to view and observe the young person at all times. This was successfully used at other times when detainees where know to have a history of sexual assault/ sexualised behaviour/ high risk behaviour, and was identified as a potential risk to other residents.

(c) **Do you consider the use of the blue system for Albert and Finn was appropriate?**

At the time of the sexual assault incident this is in reference to, both Albert and Finn were on yellow, and change to the orange colour. I believed they should be on Red, as the lowest approved colour of the BDS. I did not agree with the Blue colour system in the current state it was, and identified it needed to be developed into a fully robust therapeutic support program for young people, before I would endorse it as a suitable program for a young person.

As mentioned above, safety for other residents could have been managed by having these young people on Red colour, and on It would have been appropriate they were put on 1:1 supervision through the VCS process.

(d) **What should have occurred to support Albert and Finn and to protect other detainees?**

Albert and Finn should have been advised the behaviour constituted sexual assault. They should have been advised that the police would be notified of their behaviour. A referral could have been made for additional staff practice advice from a Senior Quality Practice Advisor from the Quality Improvement & Workforce Development unit (Children and Youth Services), for external practice advice on the best way to manage this, and identify improvements for the future. I am not an expert in this area, and would have suggested that a multidisciplinary meeting be held with the MDT group and other professionals with expertise in the area invited to identify strategies. From past practice experience I would suggest that Albert and Finn should have been offered psychological support- referral to the forensic psychologist, and consideration to a referral for a therapeutic program that addresses problem sexualised behaviour with an agency with specialised skills and knowledge in this area. Albert and Finn should have been supported to learn why this behaviour is not appropriate, and learn about appropriate sexual development and behaviour. It is likely Albert and Finn may have experienced past sexual abuse themselves, so psychotherapy to address past abuse may be recommended.

As mentioned above, the safety of other young people could have been managed by having these young people on Red colour, and on it would have been appropriate they were put on 1:1 supervision (The VCS previously mentioned).

(e) **In your assessment, why did those things not occur?**

It is clear that the AYDC staff were not educated or trained in identifying and understanding problem sexualised behaviour and used their personal views/ opinions to inform practice. The senior leadership staff were also educated/ trained in this, so did not provide this direction. The Centre Manager, as leader of the staff supported the view that opinions on the matter vary and did not support my view that practice decisions should be informed by nationally recognised definitions, not personal opinion. The staff at AYDC did not seem aware that practice in human services settings should be informed by evidence based definitions and guidelines on what constitutes problem sexaulised behaviour. It was seen as not a problem.

There were no guidelines or policies to advise staff on responding to sexaulised behaviour in young people. There was not training for staff on this.

Also, In the discussion at CST, the staff were more concerned with how Albert and Finn may behave if they were held accountable for their behaviour. The CST discussion was not recorded in the Minutes, however the statement was made that they would "drop their bundle" and be more difficult to manage if they went to Red colour, so it would be better/ easier for staff to manage them if they were on Orange colour. This decision I disagreed with in my email to the CST group.

Your own conduct

94. **Have you ever engaged in any form of sexual or sexually suggestive behaviour towards detainees, including the use of sexually suggestive language? If so provide details.**

No

95. **Have you ever engaged in any other form of conduct towards detainees which you regard, or which you consider the community would regard, as inappropriate, whether or not it was in breach of policies on the treatment of detainees? If yes, provide details of that conduct, your reflections on why you engaged in it and why you consider it to have been inappropriate.**

No

96. **Have you ever been the subject of an allegation or allegations of physical violence, bullying, sexual abuse or any form of inappropriate behaviour towards detainees?**

No

If yes, in respect of each allegation:

(a) **what were the details of the allegation;**

(b) **what, if any, process of investigation and determination**

occurred in relation to the allegation, and

(c) **what was the outcome of the investigation and determination process?**

97. **Have you ever been placed on modified work duties or in an alternate work location because of allegations made about your conduct? If so, provide details.**

No

Sources of information for this statement

98. **Have you refreshed your memory for the purposes of this statement by reviewing any documents or other records or by speaking to any other person (other than any lawyer assisting you with the statement)? If yes, provide:**

(a) **details of each person you spoke to and the matters you discussed, and**

[redacted] (also known as [redacted]). On Thursday 28 June to refresh my memory on the matter related to Margaret [redacted] referred to in point 86

[redacted] on 1 August 2022 to refresh my memory on the process and principles of Conferencing under the Youth Justice Act.

(b) **a list of, and attach to your statement a copy of, each document which you have used to assist you in making this statement, including emails, text messages, policy documents, incident reports and correspondence.**

Other information

99. **Is there further information you would like to provide to the Commission regarding Ashley Youth Detention Centre? If yes, provide it here.**

Whilst I worked at Ashley Youth Detention Centre for a short time (just over 2 years in total), I believe I made every effort to identity and address issues as they arose, and made efforts to work collaboratively with the staff in the Centre for the wellbeing and safety of young people detained in the Centre. This was impacted by the difficulties I experienced associated with conflict that was not effectively addressed between different areas of the Centre, as well as the conflict I experienced with my direct line manager in 2019.

100. **Is there further information you would like to provide to the Commission in relation to its inquiry? If yes, provide it here.**

No

B. REQUEST FOR DOCUMENTS

101. **Produce a copy of any document referred to in response to any paragraph in**

this Notice (including any document which you used to refresh your memory referred to in your answer to paragraph 98 above).

102. **Please also produce an up to date copy of your CV.**