TRANSCRIPT OF PROCEEDINGS

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

At Kannenner Room, Mövenpick Hotel
28 Elizabeth Street, Hobart

BEFORE:

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

On 13 September 2022 at 10.05am

(Day 36)

PRESIDENT NEAVE: Thank you, Ms Rhodes.

MS RHODES: Good morning, Commissioners. Our first witness this morning is Professor Ogloff, if he could be sworn in.

<JAMES ROBERT OGLOFF, sworn: [10.05am]

<EXAMINATION BY MS RHODES:

MS RHODES: Q. Thank you, Professor. If you could please state your full name and professional address for the transcript?
A. Yes, it's James Robert Ogloff, and my address is Swinburne University of Technology, John Street, Hawthorn, Victoria.

Q. Thank you, Professor. You are currently the Dean at the Swinburne University in the - sorry, I should start again, Dean of Health Science at Swinburne University as well as the University Distinguished Professor of Forensic Behavioural Science; is that correct?
A. Yes, that's correct.

Q. You've kindly provided your resumé, for want of a better word, which is very detailed, and shows that you have been in the field of psychiatry and psychology for close to 40 years, and have been involved in a number of projects; I don't want to misrepresent your qualifications, so if you could give a brief background as to your qualifications and professional experience?
A. So very briefly, so I hold degrees in Psychology, a Bachelors Degree, a Masters Degree and a PhD and my Masters Degree is in Clinical Psychology, and my PhD is in Forensic Psychology and Law. I also have a Juris Doctor in Law and I have worked in the Forensic level Health field - in fact this is the 40th year, starting in 1982 with young offenders.

I spent the first half of my career in Canada where I held a range of roles, including being the Foundation Director of Mental Health Services for the Department of Justice in British Columbia.

I came to Australia in 2000 where I took up the Chair at Monash University to help develop the Victorian Institution of Forensic Mental Health, a statewide Forensic

Mental Health Service. I maintained that job as Executive Director of Psychological Services and Research until the end of July this year, at which point I transitioned to the university and retained a specialist - I'm sorry, a role as special advisor to the service. My work is across the adolescent and adult Justice and Forensic Mental Health Services and my research and clinical practice are also in those areas.

Q. Thank you, Professor. You provided a statement for the purpose of this Commission which is dated 22 August this year. Have you had an opportunity to read through that statement?
A. Yes, I have.

Q. Is that statement true and correct?
A. Yes, it is.

Q. Thank you. This statement was prepared prior to the Commission hearing evidence in relation to the Ashley Youth Detention Centre, but the Commission has subsequently provided you with some information, being the opening and closing of that week and the transcript of Mr Simcock, who is the Executive Director of Youth Justice Reform.

Have you been able to see any of the hearings yourself in relation to --
A. Yes, I watched some of the hearings which involved the Children's Commissioner and the Custodial Inspector.

Q. Thank you. Given your expertise working in the Youth Justice field, the Commission is very interested in any comments you would like to make in relation to Youth Justice Reform, particularly in light of the evidence that they have heard at Ashley that even currently children could still be at risk; that there's a shortage of staff which has led to restrictive practices and young people being detained in their room for 23 hours a day.
A. Yeah.

Q. So, based on those circumstances, could you outline for the Commission what are the key elements of long-term Youth Justice Reform, and then we'll look at what comments you would like to make in terms of what could be done immediately?
A. I wonder if I just start with a bit of context for the benefit of the Commission. One of the issues we face - and

I should mention that I spent approximately a year reviewing in great detail the Victorian Youth Justice System, I did so with the former Secretary of Justice, Penny Armytage, and what began as a relatively small review ended up being a very large undertaking and saw the transfer of Youth Justice from, it was then the Department of Health and Human Services to Justice.

One of the phenomenon that's occurring, and I've observed this in Tasmanian as well, is that, while we see a reduction in the number of young people coming into Youth Detention in particular, what's happening is that the young people who do make their way in are actually different from what we saw historically in two fundamental ways.

First of all, because it's a smaller number of people, they tend to be people who have a higher degree of physical injury offending, and so what we saw in Victoria, just for example, I don't know what the exact data would be like in Tasmania, is that, just a decade before our review two-thirds of the young people coming into detention were there for non-personal injury offences. By the time we did our review that had flip-flopped and in fact it was now two-thirds of the people in there were for personal injury offences, so as a group they had different needs and were largely more difficult to manage.

And then the second issue which occurred at the same time is that the range of issues that young people have stemming from mental health problems, cognitive impairment problems, social disadvantage, being victims of child abuse, having histories in the Child Protection System and a range of other issues, they have also increased and so what we see is the young people who are coming to Youth Justice are now a much more complex group with a higher range of needs and they present very differently.

At the same time the systems have not kept apace with those changes and what has happened is, they were generally becoming more draconian, and so, much was said in the information the Commission heard about Ashley as having a terrible toxic culture and this, I'm afraid, was in a number of institutions across Australia; I had involvement in Northern Territory, Victoria, and I still am a member of the advisory committee in the Youth Justice System in New South Wales.

So, this is not only in Tasmania, but what's happened is we're at a crossroads in time with Youth Justice where we have experimented really with treating young offenders in detention as junior criminals, and so, the culture has really mirrored the culture of prisons, when in fact what's required is a flip-flop and to instil a culture of really rehabilitation and recovery.

So, I use in our state in Victoria the example that, you know, the population of young people in detention in Victoria is roughly the same as the State forensic psychiatric hospital, yet the staffing level in the hospital and the degree of professional staff is, of course, dramatically greater than you'd see in Youth Justice, and certainly that's been an issue in Tasmania, the lack of professional staff and really the Youth Justice workers playing the role more of, you know, prison officer than rehabilitation change agent.

So, I think that context is important because, you know, elements of what's required moving forward with Youth Justice are very different than they were, say, in 1999 when Tasmania made its last major change.

Q. Thank you. You talked about the need for professional staff and likening it to a mental health facility given the needs of the young people that are there. Currently in Tasmania the youth workers provide a lot of that day-to-day care and there is very limited mental health support. What recommendations or comments would you like to make to the Commission in relation to the need for that professional support?

A. Well, it can't be overstated what the need is, and I liked the analogy drawn in the Commission papers about, like having orderlies conduct surgery, and that's certainly my experience, is that, Youth Justice workers, although they may be well-intentioned, just do not have the expertise or experience to work in a positive way with young people, and I have to say this is incredibly challenging work and it requires a very advanced skillset.

So, it's important to note that not all young people have conventional psychiatric illness, but they all have significant behavioural problems or mental health problems or cognitive problems that really requires intervention by professionals, and so, in drawing an analogy to a forensic psychiatric service in a forensic hospital such as Wilfred

Lopes in Hobart, or the Thomas Embling Hospital in Victoria, for example, there are no guards or prison staff in that hospital, it's entirely staffed by health professions, a range of different backgrounds, and that's the sort of modelling that's required in Youth Justice; of course, you need security to guard the perimeter and to manage crises, but the goal should be the development of positive environments for young people.

We have to remember that, you know, we use words like "rehabilitation" which is really ridiculous, because for the vast majority of young people that I see, they have never been rehabilitated, so the notion of rehabilitation is really a nonsense and as a result the environments need to be positive, highly structured and designed to really develop positive social skills and meet the needs of the young people.

So, you know, really it's time for us to put the model of Youth Justice Detention really on its head and see Youth Justice as really a Human Service component rather than essentially guarding people and, you know, keeping them away from the public until such time as somehow they're ready to be returned to the community.

Q. And creating this environment, the Commission has heard a lot about therapeutic approaches and therapeutic practices, and you make comment in your statement that people dealing in the Youth Justice space need to look beyond those words of "therapeutic approach" and to look at the actual criminogenic needs of the young person. Could you explain what you mean by that?

A. Yeah, so that's a very important point. I think to a large extent even I was reluctant to use the word "therapeutic" because I think for the public it conjures up, you know, soft, fuzzy coddling of young people and that simply isn't effective.

So, in Victoria, for example, for a period of time the Youth Justice System did pride itself on what they called a trauma-informed approach, and so, the focus was really on trying to assist young people in their trauma, but it did so by neglecting what we call criminogenic factors.

What we know about people is that people are basically good, they're generally born good, and people become offenders like they become other things, they essentially

learn that. And so, for example, I'm parenthetically delighted Tasmania is moving towards an increase in the age of criminal responsibility because I have never seen a young person in Youth Justice under the age of 12 or 13 who doesn't have a dysfunctional damaged family and has really had such a bad background.

So the difficulty then is that, on one hand we can see a great need for what I'm calling broadly Human Services and Mental Health Care, but stacked up against that is the reality that, even by a young age young people have developed a range of what we call criminogenic factors, so these are factors that contribute to criminality, and they're obvious sorts of things such as associating with other young people who are anti-social and engaging in offending; it's the development of anti-social attitudes, the development of anti-social behaviours. It's also the lack of protective factors such as a stable family environment, it's the lack of engaging with school and education skills. It's also frequently and at an increasingly young age substance misuse, and so, these are the sorts of things that are criminogenic factors.

So, rather than having a sort of very generic therapeutic approach, the system needs to at once provide positive environment and at the same time very squarely address those criminogenic factors, so it's working with young people to change their attitudes, change their behaviour, and provide them with support for things like substance abuse, mental health and also, where possible, working in what we call multi-systemic therapy, which means with their family unit and others.

So, the approaches are actually quite complex and this is the difficulty, is what most Youth Justice Centres do, including what Ashley did, is you have often a small number of psychologists potentially on site, often poorly trained because, of course, it's typically very difficult to recruit and retain, and therefore they're often willing to take people with a lower skillset.

The second thing is, you have very limited psychiatric care, and that was in fact a recommendation we made in reviewing the Mental Health Services at Ashley with the Custodial Inspector in 2017/18, where I believe at the time they had a fly in, fly out psychiatrist who visited.

So, the mental health professionals - and I should say then there's a dearth of others. Speech pathology is often unheard of, occupational therapy, social work. So, the mental health professionals do not become part of the actual team, rather they're seen as ancillary staff members there for a particular function. Whereas, a better approach would be to have this Multi-Disciplinary Team working together so that all interactions with the young people are really seen as having therapeutic underpinning.

The best example probably arises from some of the information, again, that was presented to the Commission in considering Ashley where we heard of the toxic culture and some of the draconian and brutal behaviours and, of course, the message that young people get then is that, as I am stronger, then I'll be able to dominate the weaker; whereas what we want to do is again flip that on its head and have the environment as respectful but not for a minute neglecting the need to very directly address those criminogenic factors.

The evidence shows internationally that we do not do a service to young people if we don't address those issues, you know, systemically, both whilst in detention but also while in community and in transition to the community. So, those are the elements that are required: the Human Service delivery but also squarely addressing these factors that really contribute to and perpetuate offending among young people.

PRESIDENT NEAVE: Q. I have a question. When we heard the Ashley hearings we heard that I think 10 of the 11 children currently - children and young people currently in Ashley were on remand, so they presumably hadn't been diverted from the system in some way. What would you do about that issue? How would you deal with those children? Do you need to address the criminogenic factors for those children and in what context would you do it? Because I think some of these children will be homeless, they will have nowhere to be bailed, for example, and they will be homeless, some of them, so there will be all of those sorts of issues. What would you do to address those issues?
A. Yes, well, thank you for that question, and I should say that's a matter we dealt with and focused quite considerably on in our Victorian review, because from a legal perspective of course these young people haven't been convicted of anything and as a result they retain their

rights.

But the situation again as we saw it when we did our review, is that, in Victoria the data were that young people in Melbourne were being detained for 46 days on remand and, if they were sentenced, the average period of time in detention was in fact 96 days.

So what we found is that, during that period of remand, it was really the worst of both worlds: young people weren't receiving services except for the basic Mental Health Services and Health Services, but they were exposed to all of the toxic culture and of course the influences of other young people.

So we suggested that there be services addressing criminogenic needs among the remand population notwithstanding the concerns that the young people have not been convicted. And we did, you know, we investigated to some extent including a meeting with the Director of Public Prosecutions because one of the concerns that clinicians have about working with people on remand is that it's very difficult to discuss matters such as their behaviour because they may disclose, for example, and may incriminate themselves by providing details of their offending.

So one of the things that we recommended, and this is being considered now, is that again in some States the Crimes (Mental Impairment and Unfitness to be Tried) Act which govern the assessment of people before the courts for pre-trial assessment for fitness or mental impairment actually have a provision that allows clinicians to obtain information about those events, about the allegations, but that that information cannot be used against the person in prosecution, it can only be used for the purposes of the assessment. So, for example, when I assess somebody for a mental impairment offence, I need to be able to ascertain what happened, what they were thinking and their behaviour, so in doing that, of course, they're incriminating themselves because they haven't yet been convicted, so there's a protection.

So, that's one of the issues for young people on remand, is that there needs to be a degree of protection for them to be able to speak openly, not only about offending but about general behaviour that underpins the offending, and again, clinicians are very loath to work

with young people for fear of ultimately having the young person incriminate themselves. So, because of that plight which we see nationwide of the high percentage of young people on remand and very little being done, that's really an opportunity that's so important.

The final point I'll make about this is that, as adults, we think of time very differently than a young person. So, if we can think back to when we were children or teenagers, time like 46 days, you know, that's approaching a school term, so being on remand for a period of time, again, it's the worst of both worlds because you're removed from whatever potential protections you had in society into an institution where you're exposed to that toxic culture, but at the same time no real attempts at rehabilitation are attempted, so that is an authority issue that needs to be addressed.

Q. Just a follow-up question on that. Can you think of ways of housing these children separately from children who have been convicted? And also, another follow-up question is, what do you do about continuing - so, the child is in your example for perhaps 96 days, they've been involved in working with a psychologist, forensic psychologist on these issues; what happens when they get out?
A. Yeah again, we think there needs to be - I think there needs to be continuity of care, and again, what I would be recommending and what I have recommended is that the period of contact with Youth Justice and Human Services be seen as relatively seamless irrespective of where the young person is.

I realise there's issues with the location of Ashley and the fact that young people will come from different areas of Tasmania, but particularly now with online capability, there's simply no reason that a young person can't engage with a continuous care team either electronically or face-to-face. And again, we do this - interestingly in Health it's quite common where the same team will follow a person and that's seen as best care irrespective of location.

So, it's really repositioning the intervention with the young person away from basically punishment and restrictions to intervention and deal with it that way. So those are the sorts of recommendations that we would make for that continuity of care because for young people in

particular it's very difficult to engage with them; they think even a young adult is somehow old and can't understand them, and what typically happens is they tire of telling their story again and again and, if they do open up to one person, then they feel as if they've given of themselves and it's very difficult for them to continue to do that if they don't see any real change.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BENJAMIN: Q. Dr Ogloff, Robert Benjamin here. You talk about a change in the law to ensure that statements made to a therapist were excluded from any legal proceedings so the child couldn't incriminate himself or herself, and that tends to be a retrospective approach. Would you suggest at the same time that the child ought to be warned that, if they were going to say something that's going to happen in the future in terms of harm to somebody else or harm to property, that ought - that might be something a therapist should be able to report to prevent future crime?
A. Yes, I would say that I would agree with that. I should say that that is the practice outside of detention facilities, for example, in a Forensic Mental Health Service except with child abuse. The fact is that clinicians have a different degree of confidentiality with respect to prior acts, but if they know or have reason to believe the person's going to cause harm to an identifiable person, then the ethics allow - don't require but allow the clinician to make warnings, and I know from many years at Forensicare in Victoria that that's something that was done quite frequently, is that, if in assessing or treating someone the clinician identified a risk into the future, then they would alert authorities and take precautions, and incidentally that's of course conveyed to the young person, and again as a clinician you would remind them as needed.

So, you would say, you know, you're not an investigator, you would say that, "Remember that, if you tell me things that might be happening in the future, I have an obligation to share that information", and then that's part of building a trustful relationship, and I have to say, having had to report a number of individuals over time myself I've always told them, you know, "I'm going to notify authorities", and we had one circumstance, for example, where the individual stayed in the office while we telephoned the police and the police came, and understood

that that was our obligation and they handed themself over to the police.

Q. Dr Ogloff, just a bit out of left field: if a child was brutalised at Ashley Youth Detention Centre as a child and then was sent back to a repurposed detention centre as an adult, what would be the likely impact upon that child - assume the child was a victim of child sexual abuse in or about the detention centre - they were sent back there as an adult, what could be the impact on that adult or is that too general to make a meaningful comment?
A. Well, I think two points that I'd like to make in respect of that question: one is that, of course, what we see with young people is, they are reticent of authority, particularly those in Youth Detention, and when they are brutalised - and I don't mean it has to be, you know, egregious sexual brutality, but even being called names or being treated with disrespect, obviously that just engenders a distrust of authority; so on that level that's an ongoing issue, if they return to the same facility or indeed to Youth Justice they already have a sense of this being a disrespectful environment that's quite hostile.

If they have had a negative experience in a particular place and they return there, of course, that could be very traumatic for them and I think that's just - we've all had that experience as people, I think sometimes even hospital. You know, it's different if you're in a big city like Melbourne, but say in Hobart or Launceston, you might go to the hospital, you might have had a loved one die there, so you have very mixed feelings about these environments, and if we then turn our attention to the Justice System, that can be all the more stark.

COMMISSIONER BENJAMIN: Thank you.

MS RHODES: Q. Thank you, Commissioners. I'll just return to one of the President's questions which was in relation to remandees and prisoners and whether it's appropriate or best practice to separate remandees from prisoners?
A. I think, yes, there is, it's very difficult, and again even in Victoria where the population's larger it became one of the almost puzzles was how you actually manage people, and so, because of course you're dividing by age, although with the change in Tasmania that will be different. In Victoria it was literally 10 up until the

early 20s because they have a dual track system where adults can be sentenced to a period of Youth Detention. So, you'd separate by age, you separate by gender, and of course you separate by remand.

So, what we recommended and what Victoria's trying to do in the development of a new Youth Justice Centre is very small living units rather than large units so that you can accommodate people in a way that does separate them. In practice it becomes very difficult.

And I should say, returning to my initial comment about the increasing complexity of young people and also the higher proportion of those who are there for personal injury offending is, we lose the positive exposure to people, because in Youth Justice for example, my experience in most places is that some of the older children who are sentenced can be very settled.

For example, in Victoria one of the facilities would have older boys engaged in TAFE, working, studying, and they would be very, very settled and therefore that would be - they could be a quite positive environment, but the problem is having everybody contained together in the toxic culture, of course, provides the really terrible experience but also really, I think, reduces the likelihood that you're going to be able to positively change people just because of the exposure to that.

So, in sum the trick is to have very small living units and, to the extent possible, manage young people separately but probably giving more thought to the mix of young person than just their legal status, although I realise this is highly problematic from a legal perspective and that's one of the considerations that needs to be taken into account.

Q. Thank you. We've spoken about what sort of long-term things could be done in the Youth Justice space; is there any recommendations or things that the Commissioners should be thinking about in terms of what could be done now immediately or in the short term?

A. Yes, I think there needs to be, and this is not only in Tasmania, but there needs to be a real, you know, a rapid change and even abandon the facility - I've heard people say burn it to the ground and all these sorts of things, but certainly moving the young people to a

different environment as soon as possible is very important because the environment itself and the culture is toxic.

I think we also have heard about some of the difficulties with more remote locations and that's an issue, like in our State in Victoria, that's a problem; I think they're building a new Youth Justice Centre quite far from the Melbourne CBD, whereas the current facility, main facility is in a precinct with the Children's Hospital and Youth Services, so it becomes much more difficult to attract professionals to the place.

So, it is identifying space which is in proximity to where professionals are located, that has a very different feel, but be mindful of course for the need for security and things like that. So, I realise these thoughts are not terribly pragmatic, but the fear I have is waiting. Like, again, in Victoria these recommendations were made several years ago now and the new Youth Justice Centre still isn't available and matters continue to be very, very difficult in the existing centres.

So, I think changing the physical space is important. Also staff, this is problematic because, whilst you need people who are experienced, but you need a refresh on staff, because just as young people are affected by culture, so are staff. In speaking to youth workers - in fact in the review I did it was particularly profound that a high percentage of youth workers that I spoke to were - you know, they set out to be a Youth Justice worker because the position was advertised essentially as helping young people and guiding young people, but then when they got into the role one man said to me, "I didn't expect to be pinning young boys up against the wall", you know, so they don't have the skillset. So, this is the problem, it's easy to say a staff refresh but you need to have the experience and the skillset, but remove the toxic culture component.

Q. Thank you. The Commission has heard that it's been an announcement of government that the Ashley Youth Detention Centre will be shut in 2024, and we've heard evidence from the Executive Director of Youth Reform, Mr Simcock, saying that he does not believe that that's a likely outcome - I hope that's summarised his evidence well - and that the closure of Ashley is going to form part of the entire Justice blueprint for the government, and that these two

processes are running together. So, they're looking at the entire Youth Justice continuum and the closure of Ashley at the same time.

Given the comments that you've just made, what would you say in terms of priorities with the safety of children at Ashley as being at the forefront of decision-makers' minds?

A. Well, what I've seen in the evidence before the Commission is particularly discouraging; that is, I know for as long as I've been in Australia, which is a long time now, I have had some occasion to visit Tasmania to do work there, and certainly even when we did our review five years ago now of Mental Health, there are always plans to improve Ashley, but obviously the plans have essentially not eventuated; so, I think it's easy for me because I don't have to think about the practical implications, but I think the first priority certainly within Justice and Human Services is because it's a lifetime; you know, two or three years is a young person's entire lifetime in detention.

And also, damaged youth, we know, become damaged adults. Some work was done in Victoria, for example, by Legal Aid that showed that the top 100 people who use Legal Aid as adults in the Crime jurisdiction started their history in Justice as averaged about 13. So, you are not only damaging a young person, but you are essentially creating a lifelong or what we call a life course persistent offender and, therefore, you're not only affecting a young person, but you're affecting the victims in society going forward.

So, I can't overstate the priority for Youth Justice and my experience across the Justice System, Youth Justice should be the highest priority and as we know this is one of the few opportunities to create positive change in people who might otherwise go on to have a career of causing misery to others and indeed having a miserable life themselves.

Q. Thank you. I think I've got one more topic we can traverse before the time is up. I want to talk to you about harmful sexual behaviours in detention centres. You talk in your statement about, children who enter the centres are usually quite damaged and have been victims of sexual abuse before they enter the system, and you talk about being socialised into an abusive environment and then

moving into a detention centre which is abusive itself.

Could you explain to the Commissioners what you mean by an abusive environment and how the experience of going into detention can compound - well, is a similar environment, but also is an environment that is authorising or allows for a culture of harmful sexual behaviours to occur?

A. Yeah, so and this is obviously a very large issue. I think in short what happens is, and I have a lot of experience in this area and one of my roles is on the Therapeutic Treatment Board in Victoria which is a board under the jurisdiction of the Children's Court which recommends treatment orders, therapeutic treatment orders for young people that engage in harmful sexual behaviour.

What we see with young people engaging in harmful sexual behaviour and being exposed to harmful sexual behaviour is that it has a profound effect on their identity, and of course fundamentally the boundaries and their experiences with sexuality.

So, boys in particular, while they're in the prepubescent and pubescent years have of course significant changes that occur biologically and it's accompanied by a high sex drive. So, what happens to average boys, that they're socialised in a positive way by the family, by society, they learn more and more about matters of, like consent, they learn about appropriate relationships, respect. So, young people who have been violated sexually by whomever instantly have that veil pierced, and so for them, you know, taking advantage of someone sexually becomes par for the course, and so the first thing that happens is the sense of boundaries evaporates. Some of my research has been on repeat both victimisation but also the relationship between being a victim and being a perpetrator and we see people who are sexually abused are more likely to be victimised again but are also more likely to become a perpetrator and this is largely because of those psychological and societal mores being damaged.

So, if a young person has already had an experience of abuse - and I should say that the data are very clear on this, again formerly at least half of the young people coming into Youth Justice have a formal history of Child Protection and when you dig a little deeper you see a much higher percentage of people who have victimisation,

including sexual victimisation.

So, when they come into an environment that reinforces this message that basically if you're sexually aroused you can take advantage of whomever, or sex becomes a way to impose power, so again, we've heard this in the evidence before the Commission where some boys would engage in harmful sexual behaviour in what was referred to as a hazing ritual or horsing around; those behaviours, of course, reinforce the message for the young people, so these become very damaging for the individual because, of course, they feel powerless and for them it becomes potentially even normative for them so that they may themselves then engage in that behaviour to fit in or to exert power and, of course, because this is happening at such a formative period in the young person's life, we can see long-term ongoing effects.

And again, that's what's sad for me again about the need to prioritise intervention for young people, because we know that, for the vast majority of young people outside of Youth Justice who engage in harmful sexual behaviour, and the prevalence is high, that it stops during childhood. So, there's good data on that internationally that young people, the vast majority of young people have their behaviour corrected, but we also know that young people coming through Youth Justice Systems, because of the toxic and reinforcing nature of those environments, often do go on to have life course persistent behaviour problems including harmful sexual behaviour perpetration.

Q. So, is there a role here for when a young person enters detention to have a comprehensive assessment to identify their background and their needs?
A. That's absolutely critical and just to emphasise: again, if we flip around what is Youth Justice, and I've similarly done this with adult Corrections is, these are Public Health opportunities and it's for a young person Mental Health opportunities; because, again, the vast majority of young people will have had estrangement from school, difficulty from family, often a lack of appropriate services. So, it's an opportunity, when they are identified coming onto a Youth Justice order, it's an opportunity to do a comprehensive evaluation with them to identify both the drivers of their crime - what I call the criminogenic factors - but also what we call responsivity issues such as mental health, disability, learning

disability, speech problems, all of these issues; so, again, revisiting Youth Justice detention as really a public health opportunity, therefore it's an opportunity to investigate issues and concerns for the young person that can either be addressed during the order or, as we talked about earlier, in a sort of seamless transition into a broader Health or a Human Service system.

Q. Are there any risk assessments that you're aware of that you would recommend to the Commission to investigate and look at in terms of making those assessments for young people when they enter detention?

A. Yeah, so there's just a few things. First of all just on the mental health side, there are structured screening tools: one is called the Massachusetts Assessment of Youth and it is a validated tool, it is used in part of Australian states, which does a screen for a young person who might have mental health issues. There's also cognitive screens, and by "cognitive" I mean looking at learning disability or intellectual functioning or cognitive impairment.

And then, of course, on the criminogenic side there are standardised tools: the best known one is called the Youth Level of Service Inventory, and this is a tool that's used with the young person to identify the elements I mentioned earlier of criminogenic factors and also what we call responsivity issues or factors that impede the young person's ability to benefit from treatment.

So, there are certainly tools like that, but again, given the small number of young people, you know, in a State like Tasmania it would be a good investment to have a comprehensive assessment by either a clinical psychologist or ideally a clinical forensic psychologist or psychiatrist, rather than just a screen or some sort of assessment; it's a small number and it's a good investment, although individually it is costly, it can have a significant payoff over time.

It never ceases to amaze me in my clinical work how frequently we identify issues in young people, or adults for that matter, which have gone unidentified sometimes for years, including ADHD, learning disabilities, speech problems obviously, often times impairment in language, intellectual functioning, mental illness and so on and so forth.

COMMISSIONER BROMFIELD: Sorry, Ms Rhodes.

Q. Professor Ogloff, thank you for your statement and your very helpful evidence. I just wanted to pick up the point you were making about small numbers. We hear a lot about the challenge of a small jurisdiction in Tasmania; I guess the flipside is that in a large jurisdiction you've got always the issue of, how do you scale up innovation.

Listening to your evidence I have to wonder whether, given the small numbers, it's actually really feasible for Tasmania to be thinking about being nation-leading, whether the numbers are small enough to actually implement and sustain what is a Best Practice Model around custodial intervention rather than custodial detention, but I just wanted your thoughts on that, whether that might attract the qualified workforce?

A. Yes, I think so, and again I read the evidence and I think even a young person reflected on that, that there needs to be a Tasmanian solution and also there are advantages with smaller jurisdictions. I should say in my life I have worked in different sized jurisdictions and there can be advantages.

I think the only way it can be of advantage though is if we see the service system well connected to other service systems and not seen as a standalone, you know, Youth Justice or Justice System.

In fact, you know, going back many, many years when I was in the United States for a period of time in a State that had 80 counties and each county had its own sheriff and in fact Mental Health Service, and in one county the deputy sheriff was in fact the Director of the Mental Health Service, and so, they were connected.

And so, in Tasmania the analogy would be having again a seamless service between things like Education, Mental Health, Disability, now the NDIS, so that a young person irrespective of whether they're in detention or under a Youth Justice order or in the community are cared for by a Care Team that isn't delimited by the jurisdiction under which the young person falls, and we certainly see this, I know this happens in Tasmania with secure welfare, you know, young people go from secure welfare into Youth Justice and back and forth, and they're siloed rather than

connected and providing that support

MS RHODES: We've got five minutes left, so I might just take one more topic.

Q. We've spoken a lot about people in detention, and you've also made a lot of comments in your statement in relation to treatment of victim-survivors who aren't necessarily detainees or involved in the Criminal Justice System, so I just want to reflect on the evidence of Mr Boost who was a lived experience witness yesterday who explained to the Commission that when he was a child and being abused he didn't understand that that was abuse, but when he turned into a teenager, 12/13, that's when he started to reflect and realise that it was sexual abuse. Is this a common experience for children who are sexually abused at a young age?
A. Yeah, absolutely common, and in fact we have a large research program, in fact we have the largest sample in the world of people who were confirmed to have been victimised as children - this work predates my time in Australia, it was done by Professor Paul Mullen, now Professor Emeritus of Psychiatry, and the team began to identify a cohort of young people who were confirmed to have been sexually victimised from 1965 up until about the end of the 1990s, and we have followed these people up now, some for 45 years.

The first thing, just reflecting on your point, what we found is that the people who have had the worst outcomes were in fact those abused typically aged 12 or older, and it's because of the cognitive realisation of what's happened. I worked many, many years ago in a Children's Hospital with children who were abused and it struck me as a young man that the kids didn't realise they were being abused, they still loved their parents or whoever was abusing them, and it was painful, they had this sensation of pain but they didn't connect that this was a sexual act.

What happens again, for all the reasons we know, by the time the young person becomes an adolescent and becomes aware of their body and matters of privacy and sexuality, that's when all these issues become compounded. One of the dilemmas that we faced, for example, is that, in cases where young people are abused in infancy but there's no - did not continue to be abused, the parents often say, well, should they inform the child that they were abused, because

obviously they have no memory of it, so that can be damaging.

So, emphatically the answer is yes to your question, that is problematic and therefore we need to be able to deal with not only the sort of physical side of child sexual abuse but very much the psychology of it.

And I should say again, it's damaging to both girls but also boys, and for boys in particular what I've seen is that, because most perpetrators are men and most boys are heterosexual they have both the experience of abuse, but then they have the stigma around, you know, perceived homosexuality and then it becomes incredibly damaging for people, so those factors do very much need to be at the forefront when we're dealing with these experiences in young people.

Q. And, is it also important for anyone who's providing services to these young people to be conscious of their age and cognition when they're providing treatment?
A. Oh, yes, absolutely. Again, you know, the rule of thumb is that, you know, it doesn't matter what it is in life, whether it's a grandparent dying, young people understand things at their own level and of course the intervention needs to be guided accordingly. So, we can do, and there's evidence of sometimes doing a lot of harm by trying to introduce concepts that are beyond the cognitive capacity of the young person, but at the same time we mustn't just ignore these matters, we must be prepared to deal with them at whatever developmental stage the young person's at.

MS RHODES: Thank you, Professor Ogloff, that takes me to the end of my questioning; if there's anything from the Commissioners?

PRESIDENT NEAVE: Thank you very much, Professor Ogloff, that was very helpful.
A. Thank you.

MS RHODES: Thank you, Commissioners, that completes our morning session. If we could take a break now.

SHORT ADJOURNMENT

MS BENNETT: Commissioners, the next two witnesses appear

as a panel, Mr Cartwright and Ms Shuard, they appear remotely, and if I could ask that they be sworn or affirmed.

<**TIMOTHY JOHN CARTWRIGHT**, **sworn**: **[11.34am]**

<JANICE MARGARET SHUARD, **sworn**:

<EXAMINATION BY MS BENNETT:

MS BENNETT: Mr Cartwright, could you please tell the Commissioners your full name and professional address.

MR CARTWRIGHT: Timothy John Cartwright. I am at an address known to the Commission which is from my residential address.

MS BENNETT: Thank you, and you've made a statement to this Commission, is that statement true and correct to the best of your knowledge and belief?

MR CARTWRIGHT: Yes, it is.

MS BENNETT: Thank you. Ms Shuard, you've likewise made - can you tell the Commissioners your full name and professional address?

MS SHUARD: My full name is Janice Margaret Shuard, and I work from home which I have provided in my statement.

MS BENNETT: Thank you. You've also made a statement. Is that statement true and correct?

MS SHUARD: It is.

MS BENNETT: Thank you very much. Mr Cartwright, you have a background in a long history in policing, and you became an Implementation Monitor following the Family Violence Royal Commission in Victoria; is that right?

MR CARTWRIGHT: Yes, that's right.

MS BENNETT: Roughly, when did you start that role?

MR CARTWRIGHT: 2016, August 16, and I was there through - for three years, so to August 18, I think it was. Have to do my maths: 19.

MS BENNETT: Ms Shuard, you have a substantial background in Corrections, and then, you are the current Implementation Monitor; is that right?

MS SHUARD: That's correct.

MS BENNETT: I'd like to talk to you about implementation science. Can you, Ms Shuard, tell us what that is?

MS SHUARD: I guess implementation science is about the process that should be gone through in terms of achieving good implementation outcomes. So, that is the science, I guess, of understanding or seeking to understand what has been done in the process of implementation. So, has the right research been undertaken as the foundation of what is going to be - of what is wanting to be achieved; have the right people been consulted and engaged in the process; is there a plan about how it will be put in place, and I guess importantly, is there an ongoing review process to ensure that what it is that you're wanting to achieve is actually being achieved by the implementation of whatever it is you're wanting to put in place.

MS BENNETT: So, you both have experience following the Family Violence Royal Commission, which I should pause to acknowledge was chaired by our own President Neave; that Royal Commission had 224 recommendations. Starting with you, Mr Cartwright, how do you go about carrying out the role of Implementation Monitor in relation to that volume of recommendations?

MR CARTWRIGHT: As part of my statement I actually found that volume challenging, but the first thing we tried to do was understand what were the foundational issues, what were the higher priorities, what was the fewer priorities and the sequence we'd like to see; that was one of the things that as an Implementation Monitor we put in place to develop our own plan about how we would go about that. When I say "our", I mean the Implementation Office and the Monitor.

And conversations; once you have those fundamentals laid out, conversations, lots of conversations, whatever evidence you can gather and work towards that plan. And the other critical part for me was the transparency of what I was doing so that the people affected, the people doing

the work understood what we were doing and to gaining their cooperation.

MS BENNETT: Perhaps, could we start there. Perhaps you could explain to the Commissioners and those watching what it was that your office was doing. Where you obviously didn't formulate the recommendations and you weren't actually the party carrying out the implementation, so where did you sit in the process?

MR CARTWRIGHT: Probably fair to say not where I anticipated at the beginning. I anticipated that I would have in that case a plan and, like any other project, the plan would have a critical path dependencies, progress reports, timelines, decision points, all that sort of thing, and that I would be able to see that, test what was being reported in various ways and then report back to the Parliament.

For various reasons that really wasn't possible, so what I found myself doing was having a lot of conversations with a lot of people and using anecdotal evidence largely to assess performance and then trying to influence as we went along. So, I was both the receiver of information, I thought the role, part of the role was in the capacity to influence the success of the implementation; so, if I saw things that I was concerned about, I would ask questions and try and assist in that regard.

The other important part of the role which surprised me a little was eventually becoming in some ways, not an advocate for victim-survivors, but certainly the middle person between those implementing and those who were affected or advocating for change.

MS BENNETT: And, Ms Shuard, when you took over the role, how did it meet your expectations?

MS SHUARD: May I say, I think Mr Cartwright did the difficult work in terms of establishing the process of systems by which you would go about monitoring. I took over the role at the end of the third monitoring period to produce that report. And then, I guess the thing that was interesting for me is, the fourth monitoring report was according to the legislation to be the last report, so that was a very comprehensive report because I took the view that it was incumbent on us not just to look at the

previous year but to look at progress thus far since the Royal Commission and produce the report that was produced then.

But I guess it was really important to me, in doing this, was to hear the voices of everybody involved. You know, I say you have the designers and the funders of the system, you have the service providers who deliver the services, and you have the victim-survivors who are most important in terms of experiencing the changes in the system but, more than that, influencing the design of the system so that it meets their needs and I think that's absolutely critical.

I think a view that our job was, a bit like Tim, is to add value to the outcomes for the family violence systems, so therefore to provide an independent view by listening to all of the voices that were involved in the system, and sometimes there's a difference, I guess, of view about how it's going, what's working, whether it's being effective in its implementation, and to be able to represent all of those voices so that the designers of the system and the users of the system and those delivering the services get a shared understanding of our independent view.

MS BENNETT: So, returning to you, Mr Cartwright, is it a matter of having a spreadsheet with Recommendation 1 down to Recommendation 227 and a tick when you've got there?

MR CARTWRIGHT: No, that's far from it, thanks for the leading question. As I say in my statement, the outcomes are critical. So, while there are specific recommendations, those recommendations are really about the outcomes to be achieved. And, while it's simple and tempting to tick things off, as Jan said, you've got to go back to the people in the system, all those players and ask them, is this working, is it working the way we want, how can we make it better?

So, that critical question I always asked was, what would make this better for victim-survivors and future victim-survivors and perpetrators? So, that was what led everything: rather than the ticks it's, is this working to produce the outcomes that the Royal Commission in that case wanted.

MS BENNETT: Turning to you, Ms Shuard, about the

relationship between the recommendations themselves; how did you come to understand the relevance of Recommendation 10 to Recommendation 53?

MS SHUARD: I guess, you can't look at every recommendation, you have to choose which ones you're going to explore in more detail and, as you said, tick off. The government has a very transparent system for reporting itself and determining itself whether a recommendation has been acquitted. So it's, in my view, not for a Monitor to decide whether it's been acquitted and ticked off or not, but the Monitor explore further to see if it's meeting the outcomes that were intended by that recommendation.

MS BENNETT: So, can you give an example about, well - what about unintended consequences? So, for example, if the recommendation was to put in place a particular process but in your assessment it wasn't having the effect that you discern the Commission had in mind, how do you respond to that?

MS SHUARD: Well, for the first four years we were required to do an independent report to the Parliament and that was to look over the year before, from November to November, so that really focused - the legislation focused our effort on what had been achieved during that year, so that, if you like, for me decided where were the areas we were going to explore and see if they'd done what they needed to do.

Following that the government extended the function for a further 18 months but without the requirement to table the report in Parliament, and we were able to suggest that we should be doing a series of deep dives into critical areas of the reform, and that was agreed that we would do that, and to guide us in - so, what were those areas that we needed to look at? We went out to the stakeholders and the service providers and we asked - or we did have some sort of framework for ourself because in our fourth report we called for submissions from the public and the service providers and we were - it was very generous in terms of the submissions we got and that guided us with what was important to the people in Victoria around the reforms.

But then we went to the sector and asked them, where was the areas that they thought that the independent

Monitors work could add the most value in this last 18 months, and effectively they guided what were the seven topics that we've chosen to have a deep dive in.

Now, one of the examples of that, the first topic was the accurate identification of a predominant aggressor; and, to be honest, that wasn't on our list. The two recommendations related to that had been acquitted and ticked off, however, this was of great concern to the legal sector, to the police, to victim-survivors and to - service agencies were all aware that it wasn't working as it had intended to be working. So, we did a deep dive into that area and there was no doubt the recommendations had been acquitted, what had been recommended to be done had been done, but it hadn't made a difference to accurate identification.

So, when I'm talking about that I'm talking about misidentification of the predominant aggressor when people - when the police attend, when people go through the courts, how often women will be identified as the predominant aggressor in a situation, when indeed it's the male partner that is the aggressor, and that can be for all sorts of reasons: profiling of the victim-survivor, it can be because of language barriers, it can be because - but what we found is that the orders and rules around how to identify the predominant aggressor were very clear, very clear because they had been changed; it was the actual interpretation or the practice that needed improvement.

MS BENNETT: Turning back to you, Mr Cartwright, and perhaps I'll be careful in how I phrase this question, but what is it that in your view and in your experience makes a good recommendation from an implementation point of view?

MR CARTWRIGHT: There are two aspects. Sometimes you need specificity and strong, hard measures, but in my experience most of the time you don't; you have a general direction, the outcome that's desired and a way of going about it, but you allow the owner of that recommendation, those who will be accountable, to take some possession of it to develop it. Because, if we're asking the people implementing these recommendations to go and talk to the victim-survivors, or whoever it is they're working with, then we should also give them the opportunity, the implementation person to have their own input and allow them to build their own commitment so that, when they have implemented the policy,

they have ownership of it as well as accountability.

Again, I'll just go over it. So, you have a clear outcome desired, a general direction, and you will enable them to build ownership and develop and implement in their own way and then assess the outcomes, is it doing what's it's supposed to do, rather than that tick we talked about earlier.

PRESIDENT NEAVE: Can I just ask you a question about that. The feedback processes that you got, both of you while you were doing your work, did you get - I'm not asking necessarily about family violence - but did you feel that the people who were putting those policies and practices into place, were they able to come back to you and say, "Look, we have this practical problem with doing it this way and we want to change it slightly"? I mean, in other words, go behind the intent of the recommendation and work out a better process; is that something that you experienced, that you encouraged and experienced?

MR CARTWRIGHT: Perhaps I'll go first, Jan, if you don't mind. I think, if I recall, the Royal Commission recommendations for family violence, Commissioner, you actually built that into the text, and my recollection was that you actually said in the text, here's where we want to go, and we've made the recommendations, but really it's about the outcomes rather than the wording.

So, yes, I did see - to answer your question, yes, I did see that, I did hear people say to us, "Look, this isn't working we want to do it this way", and that conversation enabled me as the Monitor to say, "Yeah, look, if this is going to better achieve the outcomes, go for it".

So, I did hear that, I did see that, and that was very encouraging, because one of the things I experienced, and I expect you're experiencing, is so many people in the system so committed to doing the right thing, but being frustrated from time to time. So, it's not - you don't start from a zero base, you actually find people, good people, well-meaning, and that's easy then to enable them to make those sorts of choices and observations.

Jan, I'll leave that next bit to you, if you want to add to that. Sorry if I rave on a bit, but I get wound up

on this.

MS SHUARD: No, Tim, you're fine. I think for me one of the absolute critical roles of the implementation Monitor is the relationships that you can build with the government agencies, the service providers and the victim-survivors. I think the transparency. The Monitor is a small office relatively to the task, and you couldn't do your work justice without the absolute cooperation, transparency of the agencies that you're working with.

So, there is a shared understanding from both sides, I think, a shared understanding by the Monitor on what has been done, how they've gone about it, whether there's been any barriers, some of the frustrations, and they're open and transparent. But I think the same applies to the Monitor, so that when you form your independent view and you do a report, the process of providing that report to the government agencies that are affected, allowing those government agencies to have input into that report insofar as, not just factual errors, but if they think you've been unduly harsh perhaps or haven't captured a point correctly, then it should be - it's open for them to provide that advice back to the Implementation Monitor.

I don't think - I'm sure Tim will agree, nobody ever wants to produce a report that's not accepted and, firstly not accurate, but not accepted, and so, our practice has been not only to go through - and we do get a lot of feedback on the reports, people are proud of their work, want it to be acknowledged, and sometimes sensitive to the findings, but we will provide them with a (indistinct) sheet for every piece of feedback that we get which will say whether we have accepted it in full, and we will only accept in full if they have the evidence to support it, and partially accept it and the reasons why, or not accept it or why we can't accept it at all, and we will provide that back to the agency. Therefore, when the report comes out there is an absolute shared understanding about why the Monitor has arrived at the conclusions that they have.

MS BENNETT: In terms of that relationship with agency, is there a tension between the need for that relationship and the independence of your office?

MS SHUARD: Not in my view. Not in my view. People absolutely understand that it is an independent office and

are incredibly respectful of that even, as I said, in providing the feedback; it will be worded in a way that is incredibly respectful such as "we would suggest because of this reason" and the like. No, I think the independence comes because you listen to all the voices, it is not only the agency.

So, if we're writing parts of our report that refers to the service providers, then they also get the opportunity to ensure that what's reflected in our report is accurate, and the same as victim-survivors; we go back and make sure, firstly, that victim-survivors are comfortable with what it is that we're saying; some people might have a change of heart and that's absolutely fine, they're comfortable, and it's an accurate representation so that it's equal across the board.

MS BENNETT: Mr Cartwright, in your statement at paragraph 16 and following you tell the Commission that:

> *It is critical that the legislation establishing the role of Implementation Monitor gives the Implementation Monitor independence, and the ability to report free from interference.*

Can you tell us a little bit about why it's important that that be established in that way and how that influenced the work that you did? I might ask you to come off mute.

MR CARTWRIGHT: Hopefully that will only occur once.

MS BENNETT: Thank you.

MR CARTWRIGHT: I'm mindful that this is a public discussion, but as a rule there is - I think there is a tension at least between those who seek to serve the government as the elected government and someone who might be critical of the government, and my conversation with people in similar roles make similar observations, so the legislation removes any doubt that the voice of a critical Monitor or a critical person will be made public regardless of whether the bureaucracy or the government of the day agrees or disagrees with it, so that was very important to me, probably more so as you establish those roles rather than further down the track where it assumes a business as

usual arrangement. But I still think that some protection of the Monitor's independence and right to speak publicly is very important as a foundational aspect.

MS BENNETT: Was it part of your role to look at the governance structures that the state had put in place around the implementation, or was that - when you're looking at the implementation are you looking at the governance structures that are there to make them effective?

MR CARTWRIGHT: Yes, I think that's an unavoidable part of the role. The legislation for me said that I would report on the plan and progress against recommendations; I don't think you can do that unless you look at the governance structures, so what are those foundational aspects they've put in place to give the greatest chance of success, and a critical part of that governance for me is around the accountability measures: who's responsible, is that clear, are they specifically held to account in a timely manner.

MS BENNETT: Can you give us at a high level what that looks like? What does that accountability look like in the context of Royal Commission recommendations?

MR CARTWRIGHT: It is going to vary. At the end of the day it's going to be up to the government of the day of course to implement as they see fit and to set up the governance structures. But there is a lot of discussion and management observations around shared accountability which I absolutely understand, but in my experience at the end of the day there has to be a single person accountable for at least identifiable aspects.

The only time that I've heard of this, of shared responsibility working was a New Zealand example, which probably wouldn't surprise most of us, but where the individual Ministers were held accountable and the accountabilities were written into their performance plans. So, people have to have some skin in the game even if they shared accountability.

So, sorry, have I answered your question or have I strayed a bit?

MS BENNETT: No, absolutely. I want to just follow up - I think President Neave wants to follow up though.

PRESIDENT NEAVE: Q. I have a question: there were some other mechanisms of accountability in that report. You've got the report to Parliament, there was also a sub-committee of Cabinet, and there was also the Secretaries Board had a family violence committee. How did you interact with those other accountability bodies? For example, did the Secretaries Board say, look, we'd like to know whether the things that were the responsibility of, say, Communities are working well with the things that were the responsibility of Justice, for the sake of - they're just examples.

MR CARTWRIGHT: Yes, I understand your question, thanks, President. I was concerned that those mechanisms, the Secretaries Board, for example, wasn't as committed as it could be to driving accountability. So, while there was shared responsibility, I was concerned that there wasn't individual commitment from a lot of those Secretaries. They have their day jobs, their business as usual jobs which are demanding and then the family violence role. So, while the structure should have been able to work, I was often concerned that it didn't work as well as it could.

I had interactions with them, I presented to the boards. I would have liked, for my example, this is an observation, a more robust discussion, more debate about what wasn't working, more enquiring. So, the structure was there, the governance structure was there, but I don't think it was enough to drive the way I would have liked to have seen driven the implementation of the recommendations and the outcomes.

PRESIDENT NEAVE: So, in effect, you presented to them, you kept them informed, but you didn't feel you got that interaction between the various portfolios, for instance, which might have been useful?

MR CARTWRIGHT: Yes.

PRESIDENT NEAVE: And, I'm not reflecting on family violence here obviously, I'm thinking about the structures that we might think about recommending here.

MR CARTWRIGHT: Of course. So, again, while the mechanism should have worked, it didn't work as well as it should have, and at some stage later in the piece I don't think

that sub-committee of Cabinet had met for at least six months, so that was a reflection. So, while you may choose to recommend a structure like that, again, the accountability mechanisms, I would say, would need to be sheeted home to individuals as well, or part of the recommendations that there are performance measures in place at the highest level as well as at other levels for delivering on the recommendations that you put forward.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Ms Shuard, I was going to ask if you had anything you wanted to add on that topic from your perspective following.

MS SHUARD: No, we did a report on governance and we thought that that was necessary in one of our deep dives because in 2021, I think, there was a whole change to the governance arrangements and that was absolutely understood, there was very broad representation in the early days of the governance and that was also, in my view, understandable; when you're starting such a huge reform program you're wanting so many parts of the government and the service sector to be involved, and then the new governance arrangements were put in place and we thought it would be good for us to have a look at that early before it got too settled to be able to offer out our view around those governance arrangements. I think they were much more streamlined and much more focused and responsibilities were clearer.

MS BENNETT: Are you able, Ms Shuard, to identify at a high level what are the key governance structures that are necessary for an effective structure? Is it minutes, agendas, is it single accountability? Are you able to identify some of the factors at a high level?

MS SHUARD: Firstly, I think it has to be inclusive. If you're doing a broad reform as the family violence reform it involves a whole range of agencies; you know, you start from the Justice agencies, across the Human Service agencies, the Education, it has to involve all of those because it plays a very important role in terms of coordination, making sure, one's not being left behind or indeed not keeping up with the rest of the reforms which could impact records, could impact on the others.

I also think that the other part of it has a critical role in identifying whole-of-reform risks. You know, 227 recommendations: everybody can do - department heads are accountable for the recommendations that they have to acquit, say the courts for example and the specialist family violence courts. What's important about it is, how does that integrate with the other service systems? How does that integrate with what Victorian Police are doing, for example, in the way that they are working? So integrate and not duplicate I think is important.

So, in my mind the essential part of a governance arrangement is focusing on those system-wide risks. What if one party's not funded? And not everything gets funded to the extent to which people would like, and so, how are the priorities decided then if that's going to affect the whole driving forward of the change agenda?

And I also think it is a mechanism for individual agencies to be accountable back to the state board, if you like, the Reform Board, on what they are doing; so reporting back so that there's a shared understanding of what's happening across the whole reform.

And then of course the Reform Board's role really is to identify any system-wide risks or issues and bring that to the attention of the Secretaries Board.

MS BENNETT: Mr Cartwright, I see you nodding along, is there anything you would add to the necessary structures for good governance?

MR CARTWRIGHT: No, it just reflects the benefits of this sort of panel that Jan picks up on, things that I miss and vice versa, that integrated piece is very much important, it's a systemic approach. So, in the current Royal Commission, you in the current Commission, you're looking at state institutions for children, but we know that there are factors that lead into kids coming into care, the young people coming into care, and then the transition out of care are as important as what happens in the facility.

So, yes, that systemic view is very important and, while the Commission of course has its scope and its terms of reference, then there is the broader system that will affect that, so I'm just very strongly supporting what Jan said around integration and identification of risks and

consequences of where things don't go as they might be planned or intended, how that is worked through.

PRESIDENT NEAVE: Can I just ask you, what's the mechanism by which you would ensure that that occurs? Is it a Reform Board of which the relevant Secretaries are members, is it an inter-departmental committee? My experience in the past of inter-departmental committees is that often things get lost.

MR CARTWRIGHT: Yes.

PRESIDENT NEAVE: What is it? Any particular suggestions about what you think might work, and you've said the Secretaries Board mechanism didn't work particularly well, and I don't know enough about structures here to know whether it would here, but is it requiring the Secretaries, the relevant Secretaries, to meet regularly and consider reports from the Implementation Monitor or initiate things themselves or what?

MR CARTWRIGHT: Probably all of those things, President. The other thing I'm a great fan of is independent participation. So, if you open even things like the Secretaries Board up to someone with expertise, even if that expertise is treated confidentially and only to the board, it helps; it helps to think that, oh, someone else is listening in, someone else who actually has a real commitment and understanding.

So, I would have thought that a suggestion around that sort of independence - not scrutiny but advice or participation is helpful, opening it up so that someone knows what's going on. You would hope that the recommendations that have been put in place such as the Secretaries Board would work, would work well, but often it comes down to personalities, to time and availability.

Perhaps I can reflect more on what else and, if I have some other observations, come back to you on that, but I agree with you on inter-departmental committees, while they can be useful, again it can very much rely on someone coordinating and driving that and being passionate about that amongst the IDCs.

MS BENNETT: I can see Commissioner Bromfield has a question.

COMMISSIONER BROMFIELD: Mr Cartwright, I recall in your statement you talking about some of the challenges of monitoring implementation when you didn't have clear interim outcomes or deadlines, milestones, built in. What is the role of the governance groups in really assuring itself that there are very thorough implementation plans?

For example, here we've had a government commitment to shut down the Ashley Youth Detention Centre, it requires a blueprint, new facilities, new practice model, new workforce; how would you monitor something that's going to take multi years in that context and what's the role of the governance group in ensuring there's a very strong Implementation Plan?

MR CARTWRIGHT: My experience post-monitoring with other boards is that the board, in whatever form the board might be in, has to be quite demanding around the plans that are put in place and the measures that are put in place and the reporting back to it, so I would say that is a fundamental piece for success.

Other aspects of it - sorry, what else were you looking for, Commissioner Bromfield, around how your longer term issue of success?

COMMISSIONER BROMFIELD: I was looking at the role of the governance group in ensuring - what should they be demanding of implementation plans?

MR CARTWRIGHT: Yes, so I would say test the implementation - they first off should be asking for an Implementation Plan which has the components that you would expect: has a critical path been mapped out, has dependencies been mapped out, are there timelines, are there accountabilities, that basic project management stuff.

I would also think that the group overseeing that plan should from time to time seek independent advice, whether it's from someone in a role like the Implementation Monitors, or whether it's even some sort of consultancy that comes in and has a look and says, is this best practice, and refresh that.

And then that at some stage is going to transition

into business as usual whether we like it or not. Like, three or four years down the track after the Commission has delivered its findings it's going to be business as usual and then that becomes very challenging to focus back and keep and maintain a focus, because other things will have come up, other challenges will have emerged, other priorities will have emerged.

Longer term I think this is where the cultural piece comes in, so that by then you have a culture that's embedded that just asks these questions or challenges the day-to-day behaviours or the commitment to the plans.

MS BENNETT: How do you go about embedding a culture of that kind following a Royal Commission?

MR CARTWRIGHT: Yeah, and that's the hundred dollar question, or the thousand dollar question, isn't it? Again, I come back to one of the things that would lead to an embedded culture is transparency, is to encourage independence, community advice, community consultation, community scrutiny, but also encourages the people at all levels of the organisation to commit to the values that you want, and to challenge; to say to management, well, we don't think this is working".

We see it now I think in the Child Protection space with mandatory reporting, we also see it in the Occ Health and Safety space where there is a move to recognising that all levels of the organisation should be free and willing to challenge what they see as concerning behaviours or actions.

MS BENNETT: Can I test with you each this proposition: we've heard some evidence that, because of the size of this jurisdiction being smaller than perhaps Victoria and New South Wales, there are some real benefits to that; it enables people who have challenges in implementation, for example, to pick up the phone and ask about what's going on or to have one-to-one conversations through personal relationships. Is there a tension between that model and the kind of transparency that you're speaking about there, Mr Cartwright?

MR CARTWRIGHT: Sorry, I was coming off mute.

MS BENNETT: That's all right.

MR CARTWRIGHT: One of my observations in policing was the difference between the relationships in jurisdictions like Tasmania and Northern Territory and what the bigger jurisdictions expect in terms of separation of powers and authorities and accountabilities. I don't think that tension can be avoided in small jurisdictions, I think it just should be recognised and the benefits taken.

I think Jan touched on this earlier, the relationships you build are what often leads to success so that you don't have to go to the formal steps of being publicly critical because the conversation's overcome or influenced. Sorry, Jan, I think you've got something to say on that one.

MS BENNETT: Please, Ms Shuard, tell us what you think.

MS SHUARD: Sure. I agree with what you say, Tim, is we often see in our work when we're exploring our deep dive topics the changes taking place before we've even published our report, and that's incredibly rewarding. People are listening and perhaps thinking, "Oh, we should get on top of that" and you see the actual change taking place. We're very, as you were, very transparent about what we're finding, where we're hearing that, what's the concern of the community.

But one of the things I think is important to be considered is another part of the governance arrangements I think in Victoria is the family violence reform advisory group and this is co-chaired by the sector and the government, and for me it can bring to the attention of the Reform Board the impacts of the reform, so how are they working. It's a formal process and I think it's really important, it's not an individual's point of view, it's the sector's point of view or victim-survivors that are represented on that, they're able to formally raise that to the Reform Board and I think that's really essential.

In Victoria, a lot of the services are in the non-government sector and it's absolutely critical that they are able to translate how that works for them, and particularly in regional areas it might work excellent in a metropolitan area or vice versa, but in regional areas where there might be staffing issues or not the available services, they need to be able to raise those issues.

It also has representatives of the different community groups such as children and young people. Their voice must be heard in these arrangements, otherwise we design around our old constructs and forget what that might mean for children and young people, so the peak bodies or advocates for children and young people are essential voices to be heard, what it's meaning for them.

And I think we saw excellent examples throughout COVID in Victoria in terms of family violence reforms with people being able to raise those concerns, provide their advice, put things in place that addressed our multicultural community, our Aboriginal community, you know, our young people, all of the communities because what I took from the Royal Commission report is, these reforms had to be absolutely equal to everybody in the community that was affected and not tiered towards a particular group. We are a multicultural diverse community and so therefore that was critical from my perspective, and also the regional voice, and I know Tasmania is little, but it still has regional representation.

MS BENNETT: It sounds as though there's a lot of work to be done from the perspective of commitment at all levels, at government, non-government agencies, public servants and politicians. Who leads that, where does that come from in your experience? Starting with you, Mr Cartwright.

MR CARTWRIGHT: Well, stating the obvious, it's got to come from someone with passion. So, whatever position you put someone in, it's got to be someone who's passionate and committed and probably has a reputation already when that goes.

One of the things that I often reflected on for the Family Violence Royal Commission was the idea of a separate senior bureaucrat, so a Deputy Secretary responsible for - at least in the initial years for the implementation. Rather than doing the work as part of their business as usual and on top of their day jobs, I would have thought that the appointment of a single coordinating senior bureaucrat would be one of the solutions which may well work particularly - well, if they're employed for that purpose, then they're accountable for that purpose. But, as Jan says, they would need the experience and the recognition of all those intersectional pieces that come into account and the differences between rural and city.

So, they're going to have to be good listeners as well as committed.

MS BENNETT: Before I turn to you, Ms Shuard --

COMMISSIONER BENJAMIN: Can I just interrupt for a moment?

MS BENNETT: Sorry, Commissioner Benjamin.

COMMISSIONER BENJAMIN: Ms Shuard, Mr Cartwright, I'm probably doing what the Commission said we shouldn't do, which is being specific, not general. But we heard yesterday that the State Government gave, in a sense, some legislation in the relatively near future to set up a Child Safe Commission, it's going to be tasked with the job of implementing Child Safe recommendations from the National Royal Commission.

Would it be appropriate, or thoughtful, to attach a skilled implementation scientist, with the passion that you're talking about, Mr Cartwright, through there by way of delivering the oversight and monitoring that you set out in your reports? I'd appreciate your thoughts in relation to that.

MR CARTWRIGHT: My experience with the Children and Young Persons Commissioner in Victoria is that that is a very successful model, and I would have thought that in that case she's well placed to do the sorts of implementation given the resources, given the connections that already exist, so that is potentially another very useful model. Others might have views on whether the umpire can be the Implementation Monitor as well, but again in a small jurisdiction, to overlap those roles or to integrate those roles may be a very useful and effective solution.

And sorry, Commissioner, if I can come back, I said don't get too specific on your recommendations: that's only a rule of thumb because there are times where the recommendations I think need to be very specific and very detailed, particularly when there's evidence of other recommendations in the past failing, and sometimes it's important to get out the stick rather than the carrot. Sorry, does that answer your question?

COMMISSIONER BENJAMIN: I think you may have confused the Child Safe Commission, which is an implementation

authority, with the Children's Commissioner.

MR CARTWRIGHT: Yes, I have.

COMMISSIONER BENJAMIN: I wasn't suggesting you put that in the office of the Children's Commissioner, but if you think it's a good idea, tell me. But if you had an Implementation Commission which we were told yesterday was going to be independent and independently funded and properly funded, whether those skills that you refer to might fit well within that structure?

MR CARTWRIGHT: Sorry, yes, I did confuse the roles, you're correct. I think that - I again think, without a great deal of thought and reflection, I would have thought that that, again, could work quite well; that someone with public responsibilities and integrity and guaranteed independence could easily fill the role that Ms Shuard and I fill as Implementation Monitor.

COMMISSIONER BENJAMIN: Thank you.

MS BENNETT: Ms Shuard, did you want to add anything to that?

MS SHUARD: Only, and I probably got the two things a little bit confused, but only that I'd say that, I don't think you can combine the roles of implementation and monitoring. I think, if you're in charge of implementation, you can't possibly monitor, or if you're in charge of the framework for implementation and all the elements of it you can't possibly be an independent Monitor. And I guess I've taken that strong view sometimes when asked, "Well, how should we do this?", if we've provided recommendations to - it needs strengthening - or not recommendations, we don't provide recommendations, I've taken that view as well, but we've made suggestions, suggested actions that something needs strengthening or needs attention or needs to be done differently.

I've sometimes been asked, "Well, how would you do it?", and my answer is, "It's not for the Implementation Monitor to tell you how". How can you be an independent Monitor if people are taking your guidance and direction to do something and then come back later; I don't think you're independent anymore. So, I think the function of implementation has to be, in my view, completely separated

from the function of independence in monitoring.

COMMISSIONER BENJAMIN: I apologise, Mr Cartwright, for not making myself clear in my questioning, but it'll be interesting to see whether the Child Safe Commissioner proposed by the government in the near future is an implementer or a Monitor and that might have some impact on what our thinking and what our recommendations may or may not be.

MS BENNETT: Mr Cartwright, you said earlier that you need someone with the right reputation and I wanted to come back to that. What reputation does the Monitor need to have?

MR CARTWRIGHT: Yeah, I struggled with this in my own statement. It's not just - well, one of the things that the Monitor has to have is not just the personal integrity, but it helps to have a reputation for integrity, or to have come from a background where the community accepts the integrity; because, while you build relationships, it is very helpful if you hit the ground with a certain reputation and a certain belief and willingness of people to approach you and speak to you, and you can get that in all sorts of ways. I would say, you know, history and a judicial role or a policing role, or in Jan's background, Corrections, or it's something where you have held an office which the community, and particularly the community affected, particularly the stakeholders will say, "Okay, that's a good foundation". Even if they don't know the person, they know the person has carried out a role which would give them some comfort of independence, resilience and integrity.

MS BENNETT: Ms Shuard, would you add anything to that list?

MS SHUARD: I come from an unusual background to do this, but I was surprised that many, many people that I already knew that were a part of the transformation or the reform program, and relationships, if you like, with Victoria Police, with the courts, with the Human Service agencies, so I guess you build on those relationships.

One of the relationships that has been incredibly valuable to me has been - that I had with the Aboriginal community in Victoria. Both Tim and I have been part of the Aboriginal Justice Forum under the Aboriginal Justice

Agreement, and I didn't speak about that before but I do want to make mention of the Dhelk Dja Partnership Forum, which is an Aboriginal-led response to family violence and prevention, family violence in their community, and that is an incredible forum for Aboriginal-led solutions to this.

So, I think that I have been blessed with those relationships that I had already before I started the role in this area, and probably my background in having spent a lifetime working with people who use violence and attempting to find programs and services and knowing how important they were, and victim-survivors in the women's Corrections system and the Juvenile Justice System, so I guess all of that goes to whoever decides to select you.

MS BENNETT: President Neave.

PRESIDENT NEAVE: I was wondering about your capacity to commission independent research and relationships with universities, and I'm aware of a number of projects that have been carried out by researchers at particular universities, whether that has fed into what you've done, because as far as I know you haven't sort of commissioned big independent research projects about how things are working - correct me if I'm wrong about that - but would that be useful, because that's another area of expertise that might help in looking at doing the actual evaluation, data collection, that sort of thing on the ground. I was wondering what either of you think about that.

MS SHUARD: President, we have relied heavily on the research that's been undertaken by the implementation agencies.

PRESIDENT NEAVE: Right.

MS SHUARD: And that, again, is a part of how you do this work, is ensuring that that research and the like is shared with the Implementation Monitor rather than doing our own research. Although, we did get assistance when we did our piece on implementation science, we did get assistance with those people that were experts in that field, but generally, you know, it's a small office, so it's small resources, so we rely on the work that others have done either internally in terms of their own research or externally through the universities, and there's been an enormous amount produced by the universities and by the

implementation agencies; we rely on that to inform our work.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Could I ask one final question of each of you and it is this: when one is faced with significant reform on a large scale, is change really possible?

MS SHUARD: My answer to that is, absolutely. Absolutely, is that, I think I said in my statement, the incredible value of the work done by the Royal Commission into Family Violence in Victoria has - we have absolutely relied on that work; it's, like, an enormous investigation and getting to the truth, and getting to the feelings and the experiences people have had. So, with all of that work, and with the people - what has impressed me the most is the commitment of the people that work in these sectors, the commitment to make it better, you know, the commitment of the Aboriginal community to reduce the harm of family violence in their community. These people are on enormous amounts of committees and the like, but their commitment is just commendable.

So, of course change is possible. I come from a Corrections background : if I didn't think change was possible, I wouldn't have spent my lifetime working in there. I'm a great believer that change is always possible.

MS BENNETT: And, Mr Cartwright, can I ask you for your concluding reflections on that significant issue?

MR CARTWRIGHT: I think Jan's covered it very well. The other thing I would say is, never underestimate the ripple effect of Commissions such as this. So, while it might look at specific, a lot of people are listening, being informed, advocates being empowered. I'd say, absolutely change is possible and it's evidenced. I mean, if you look at family violence: while we've got a long way to go, we have a discussion, we have - the Australian of the Year comes from backgrounds related to family violence. Governments listen, people listen, young people listen; I'd say change is absolutely possible.

And again, I'd echo what Jan said around, never underestimate the commitment of people already working in

the field and the sorts of authority the Commission of Inquiry like this gives them.

I could talk at it for length, but yes, I'm very encouraged to have the inquiries and very optimistic about the capacity to change. It'll take time, it's cultural, it'll take a long time, but it's a very strong first step.

MS BENNETT: Thank you, I'm grateful. Those are the matters for the witnesses.

PRESIDENT NEAVE: Thank you very much indeed, and of course what happened in Victoria, as you both pointed out, the Royal Commission was only a start, just as this Commission of Inquiry is a start into looking at a very difficult social problem, but it's wonderful, I think your evidence has given hope to the people of Tasmania that we will bring about change, that any recommendations we make and the community's efforts as a whole will help to bring about change, so thank you very much indeed.

MS BENNETT: Commissioners, if this is a convenient time to break for lunch?

PRESIDENT NEAVE: Yes.

LUNCHEON ADJOURNMENT

MS BENNETT: Commissioners, the next witness is Ms Jenny Gale, who by reason of illness appears remotely.

<JENNIFER PATSY GALE, affirmed: [1.32pm]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Ms Gale, you've appeared as a witness before this Commission on one occasion in the past. Could you please tell the Commissioners again your full name and professional address?
A. Jennifer Patsy Gale, 15 Murray Street, Hobart.

Q. Ms Gale, since the time of your first appearance, which was at the end of the first week of the sittings of this Commission, there have been hearings concerning Education, Out-of-Home Care, Health and Youth Detention. I wanted to offer you this opportunity at the outset of your evidence to offer any reflections that you want to share

about your observations arising from that evidence.
A. Thank you, Ms Bennett. I'd like to open by indicating that my view is that the safety of children and young people should not just be an expectation, it is a fundamental human right, and having listened to the evidence particularly of victim-survivors I apologise to all victims and survivors of abuse that occurred in our government institutions.

I am deeply sorry for the failings of our institutions and leaders, and I acknowledge the lasting, ongoing and negative impact that these failings have had on them and their families. In particular, and with sadness, I acknowledge the victims of child sexual abuse who are no longer with us or who haven't been able to share their stories through the Commission.

We've heard some of their stories through the courage of their families during these hearings and I thank the families for their bravery and empathise with them knowing that the retelling of their stories would have been extraordinarily difficult for them.

I have heard the evidence of victim-survivors about feeling unsupported, about the disparity in the way in which interviews were held by various parts of our State Service and Tasmania Police, about having to tell and retell their stories to different people, about not being believed, about how children and young people and their families were treated dismissively, about how they were made to feel that they were to blame, that they felt they were treated differently after disclosure, and about their concerns that nobody noticed what was going on and, if they did, did nothing to stop it; how many victim-survivors described early behaviour by perpetrators that was not meeting professional standards but that this wasn't addressed. It was difficult to listen to but very important and I sincerely thank all of the brave people who have spoken out as part of the Commission's proceedings, including our State Servants, as hearing their stories, their sadness, their frustration, their anger and their feelings of powerlessness has highlighted that there are significant improvements that must be made across the service.

The traumas that systemic failures has caused children, young people and their families has been palpable

and I commit to doing whatever I can to effect change. My purpose as a State Servant has always been to make the lives of Tasmanians better. All Tasmanians, whatever their background characteristics are or where they live, and particularly as my career started in teaching in relation to children and young people, to do this the State Service must double down on our efforts to ensure that we put children and young people at the centre of what we do and I will play a strong leadership role in that.

Every head of agency's performance agreement with the Premier will commit them to identify and take action within their own department and across the service that will keep children safer. This commitment applies regardless of whether that agency engages directly in child-related work.

In my own performance agreement I commit to being accountable for facilitation and coordination of the suite of actions known as, Keeping Children Safe Actions. For example, implementing the initial reform of ED5 by December of this year and drafting new legislation which the Premier will introduce to mandate the sharing of information that could keep children safer by the end of this year.

I also commit to continuing to roll out more trauma-informed training across the service and to supporting improvements that will see trauma-informed complaints handling processes across the service.

Since my last appearance and statement we've continued to act on what we already know and I would be able to give updates for the Commission, particularly in what DPAC is doing, if the Commission would like me to do so.

And that will take about five minutes, but I'm not sure if you want to take that time right now.

Q. I might ask you a couple of questions and then I'll be guided by the Commissioners as to what they would be assisted by or whether that's something that could be provided in writing. That was foreshadowing from me for the Commissioners.

Before we go to that, you mentioned changes to the ED5 process. Are there additional issues concerning the operation of the ED5 process that have come to your attention by reason of this Commission and what's happening

to respond?
A. Thank you, Ms Bennett. Yes, obviously throughout the course of the hearings I've learned from the lived experience witnesses that the processes for victim-survivors and their families when making complaints, disclosing abuse and participating in investigation processes has been challenging and frustrating. And also, the hearings have highlighted for me the processes for staff reporting concerns about inappropriate behaviour or suspected abuse haven't been well understood.

In addition to the things that I just noted, in my opening statement there are a range of things that I noted when I was listening to the hearings and when I was reading the transcripts of the hearings that I wasn't able to listen to directly. Things like lack of clear communication in relation to the complaint process, insufficient or no information being provided about the outcomes of the complaint, little or no professional support offered throughout the complaints process, investigations relating to complaints taking too long. Things like no choice in relation to the gender of persons receiving complaint and complaint investigators. No neutral or safe space offered for conducting interviews relating to a complaint, no support person offered to attend interviews for complainants and a number of other things as well that I observed.

And so, one of the things that I have put in place through the Secretaries Board is that - and Secretaries have agreed to - is recommending that all Secretaries ensure that there are a number of principles embedded into their complaints management process, noting that at the moment under the State Service Act heads of agencies have responsibility for those processes.

Q. Thank you, and so --
A. Sorry, Ms Bennett, I just had to have a sip of water, I apologise. If I could just list a couple of principles, if that's okay?

Q. Yes.
A. Thank you. So, the principles for complaints management are to put the complainants and victim-survivors at the centre of the process, and the complaints processes should respond to any disclosures of abuse in a way that focuses upon the needs of the victim-survivor with support,

empathy and kindness and reflective of trauma-informed principles. They still need to comply obviously With the State Service Act 2000 and any relevant Employment Directions and any other relevant information, and they should align with the National Principles for Child Safe Organisations.

PRESIDENT NEAVE: Q. I had one question about that. Are you contemplating, as part of the reform of the ED5 process, changes to the State Code of Conduct?
A. Thank you, President, for your question. Yes, it is likely that there will be changes made to parts of the Code of Conduct and how particularly the Employment Direction 5 relates to the code.

Q. Relates to, I'm sorry?
A. To the code.

Q. Thank you.
A. Yes.

Q. Because we've heard about the legal advice which has been offered in various contexts which placed some issues which, at least in my view, affect child safety being regarded not as breaches of the Code of Conduct, for example in the context of education, the issue that the relationship between a teacher and a child occurred outside of school grounds, that sort of issue. So, the Code of Conduct, my preliminary view is that there may need to be some work done on the Code of Conduct itself.
A. Thank you, President, and some work has already commenced on that reflection which has been made throughout, and there is a part of the Code of Conduct which is about standing orders.

Q. Yes.
A. I've listened to Mr Bullard's evidence and I have asked the State Service Management Office to investigate the use of standing orders for departments which may then make clear the link between certain behaviours that must or must not occur through a standing order that then would make the link between that behaviour and the Code of Conduct quite explicit.

Q. So, that would also arise, for instance, in the Health context presumably for things like boundary breaches presumably?

A. Yes, President.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. And are they to be tailored to each of those environments? So, will Health have a slightly different content to Education or?
A. So, under the State Service Act each Head of Agency is able to make standing orders; they do have to be approved by the employer and in which case that would be me as the delegate of the Premier, and they would be contextualised to the agency in question.

Q. I see.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. Thank you. You mentioned that there were some changes to the way in which you will be using trauma-informed practice and information sharing. Taking those one at a time, can you tell us if there are steps towards embedding a trauma-informed practice in the investigation phase of the ED5 process?
A. Yes. We will be developing practice procedures and standards which will explicitly relate to trauma-informed practice and about keeping complainants informed within the parameters of the PIP Act.

Q. We've heard some evidence that there might be some amendments required to the PIP Act. Are you able to update the Commission about the position of the government in relation to that issue?
A. I think we realised that the PIP Act at the moment is a barrier, particularly to keeping complainants and/or victim-survivors informed about the status of investigations, and in its current form information that is gathered must only be used for the purpose for which it was intended and, therefore, information that's gathered as part of an ED5 investigation can only be used for that purpose, for that disciplinary sanction purpose, and so, what we will be exploring is how the PIP Act might be changed to enable complainants to be kept better informed about the proceedings of ED5 investigations.

Q. What about the information sharing between the relevant agencies?
A. There is no barrier to information sharing between

relevant agencies at the moment. The personal information that is collected through ED5 investigations, my understanding is that under the definitions of the PIP Act is employee information - is defined as employee information, and because we are the one employer, there should be no barriers to that being exchanged between government agencies.

COMMISSIONER BROMFIELD: Q. Ms Gale, I think that Ms Bennett is referring to, for example, information sharing between the TRB and Education as an example.
A. Thank you for giving that further explanation. So, at the moment, as one of the Keeping Children Safe Actions, DPAC is working on legislative reform that will enable that to happen, and we hope to have - in fact, there are, I think, over 400 pieces of legislation that relate to information, and the legislative reform will take the form of - at the moment the plan is that the legislative reform will take the form of overarching legislation that would be superior to, if you like, all other pieces of legislation in relation to that information. So, yes, Commissioner, that is the work that we're doing at the moment.

PRESIDENT NEAVE: Q. Could I ask if any consideration has been given to the training that will be necessary? Obviously public servants, State Servants have been warned in the past about possible breaches of the PIP Act and other legislation which imposes limits on information sharing, and my experience in other jurisdictions is people are pretty frightened of breaching those requirements and are therefore a bit reluctant to provide information when it's asked for. So, I wonder whether consideration had been given to ensuring that people understand that the safety of children trumps some of those other considerations and that information sharing, which is necessary to protect children, can be done?
A. Thank you, President. That has been a feature of the Tasmanian State Service culture for quite some time, and even though we know that there is no barrier to sharing that information between agencies, it has been difficult. And I think this gets to the cultural piece that will need to be a very significant part of the work that we do, not only on the Keeping Children Safe Actions but also on any recommendations that the Commission of Inquiry makes: it's one thing to enable through processes, legislation, and so on, but it is another to change the way in which people behave.

I've been reflecting on that a lot over the course of the hearings particularly in relation to ED5, and I'm not casting aspersions on any of the evidence that's been provided, and I've listened very carefully to most of it, that it is largely the - the behaviour is largely driven by custom and practice, and whilst ED5 is a global procedure for disciplinary action, there is a lot more flexibility within it currently than people are using. And I think that what you're saying is going to be very important in any steps that we take to make sure that we do put the risk of children at the centre of our thinking and that cultural and education piece is going to be very important.

We haven't got to that yet, but one of the Keeping Children Safe Actions is, though, how to encourage and support staff to raise child safety concerns, for example, and that will form part of the cultural piece. The first priority is for us to enable it to happen and then we will need definitely to turn our minds to how we change the practice of our staff.

Q. I think I recall Secretary Bullard asking us the question whether information sharing in certain circumstances should be required rather than permitted, and I must say that was an interesting issue, but is that something that's being considered, that you might have a provision that says, "Where it's necessary to protect children, information must be shared"; is that a possibility that you might consider?
A. I agree it is a possibility, it needs to be. I was listening, I think that was yesterday that Mr Bullard gave that commentary, and it is certainly something that we will consider. It almost beggars belief that people guard information as if they own it and that that would put potentially young children at risk, and so, if we need to make it absolutely clear by making it mandatory that we share information, then we will certainly consider that strongly.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. It sounds as though there's a significant culture change element to that part of the work that you've identified. Have you yet identified the steps to bring about broad cultural changes in the State Service?
A. No, but that is work that we will need to commence

once - and almost in parallel with the work that we're doing now. The work to make sure that people, first of all, understand what the requirements are is clearly going to be a first step.

So, that education campaign that I was speaking about in relation to raising concerns, and I know that part of the cultural work that we're doing has commenced in some agencies, so for example - and I think Mr Bullard may have referred to this yesterday - individual agencies are starting to build tools to help support that cultural change. I think he may have referred to flowcharts that had been developed in the Department of Education on reporting incidences of child sexual abuse, and those kinds of tools are those that we will be looking at in terms of each agency but also across the State Service.

Q. Is that custom and practice that you're referring to around ED5s and how they were understood and interpreted, is that influenced by or impacted on by advice emanating from the Office of the Solicitor-General?
A. I imagine that there are a number of factors, or I think - I don't imagine - I think there are a number of factors that lead to that. One of them I think, and probably the one that I would suggest is most in the forefront of people's minds is the way in which reviews - the outcome of reviews, for example, in the Tasmanian Industrial Commission, and that then creates a nervousness around doing things in a particular way if people feel that the decisions that they make may be overturned.

I think I would put that as number one in terms of custom and practice, and obviously - look, the majority of State Servants don't wish to be seen to be doing the wrong thing, and I guess when they receive decisions it does modify behaviour somewhat, and I think that we would be well served by having some kind of risk matrix so that people don't feel obliged to do things differently; they should be putting, not the outcome through a review at the forefront, but really the importance of what they're doing to keep children safe.

Q. We have heard some evidence, Ms Gale, about the importance of independent oversight agencies, including this morning through reporting to Parliament, and ensuring that funding is not compromised by those who are carrying out those functions. Is that factored into your thinking?

A. Some of the models that we're already using across the State Service are similar to those that were being discussed, I think, by Mr Cartwright and Ms Shuard this morning, and then they take various forms and obviously, in terms of oversight, I'm understanding your question to be referring to, say, the Ombudsman or the Commissioner for Children and Young People and so on.

Q. Yes.
A. We also have other ways of oversighting, say implementation, and I refer to the Premier's Disability Advisory Council, for example, which is an independent body which has been brought together to oversight agencies' implementation of the disability action plan. That works very well, it's independent, it's not funded, but agencies have to report regularly to that advisory committee. There is publication of the monitoring of that - sorry, it's reported publicly, and it is a very effective way of holding agencies to account for implementation.

I do think independent oversight is a very important factor in accountability and also in raising public awareness about what is happening and what needs to be improved.

Q. And, are there any moves towards enabling those independent oversight bodies to be able to access legal advice of their choice?
A. Sorry, Ms Bennett, that's not a matter for me.

MS BENNETT: Commissioners, I'm conscious that Ms Gale is unwell and we've agreed with her to address only the key matters this afternoon for that reason. Those are the matters that I've sought to explore with Ms Gale, but I'm in the Commissioners hands if there's other matters that you'd like me or Ms Gale to address.

COMMISSIONER BROMFIELD: I don't have any further questions, but if Ms Gale does have a written information that provided any further detail on the DPAC reforms, we'd be appreciative of receiving them. Thank you.

PRESIDENT NEAVE: Thank you, I am sorry you're not well, Ms Gale, and thank you very much for giving evidence to the Commission.
A. Thank you, and I thank you for the opportunity and I apologise that I wasn't able to be there in person today,

and I do have written information including answers to the questions that were sent which goes into quite some detail about those matters that you raised with me following my previous hearing, so thank you very much.

MS BENNETT: Commissioners, we've been able to move the next witness up to 2.15, so if it's convenient perhaps we might take a short break now and then hear from Dr Crompvoets between 2.15 and 3pm, and then hear closings from 3pm till 4pm, if that's convenient.

PRESIDENT NEAVE: Yes.

SHORT ADJOURNMENT

MS BENNETT: Thank you, Commissioners, the next witness is Dr Crompvoets who appears by video link.

<SAMANTHA LOUISE CROMPVOETS, affirmed: [2.15pm]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Dr Crompvoets, you've made a statement to this Commission; is that statement true and correct?
A. Yes.

Q. Thank you. You tell us in your statement that you are a sociologist and you are passionate about evidence-based reform. Can you briefly tell us your areas of expertise.
A. Yep. My areas of expertise include organisational culture and organisational change and health and wellbeing and women's health.

Q. Thank you. You tell us in your statement - or I take it from your statement that you don't much like the words "culture change". Can you tell us why that is?
A. Yes. So, I've spent probably the last 10 years doing work in various organisations around culture change, and my insights from that body of work are that culture is pretty good as a concept to start discussion and sometimes for diagnosing organisational problems, but it's not very good when it comes to accountability or being able to design solutions for things because it's such a big term.

Q. Sometimes can't we discern there might be what we might call a cultural problem in an organisation and that we need to identify and address? How does that fit in as a

precursor to change?
A. Sorry, I missed the first part of that sentence, but I think what you said was, how does culture figure in terms of change?

Q. Sure, yep.
A. Yeah? Sorry. So, I'm not sure exactly if I'm answering the question correctly, but I think one of the flaws of using culture is that it doesn't allow for people to become responsible. So, when culture is blamed at an organisational level, it tends to be a bit opaque. So, people can point to this, you know, idea of culture as the problem but regardless even if you're the leader of that organisation, it doesn't really allow for individual accountability.

Q. Put another way, is it that both everyone and no-one being responsible for a particular problem?
A. Yes, that's right, that it's this inherited problem perhaps that belongs to the organisation, not anyone in particular.

Q. And I think I understand from your statement at paragraph 21, you tell us that it focuses on the toxic parts of the organisation without showing its strengths, and that that might lead to a lack of motivation for people to play to those strengths or to work on those strengths. Can you tell us about how you're seeing that - an example of how you've seen that manifest in organisations?
A. Yes, I think basically doing a cultural review has become synonymous with finding the problems, and that's only a recent sort of change. So, looking into a culture used to be, you know, what anthropologists did, and then it sort of became something that management consultants did, and in that shift it became about looking for problems and solving those problems, yeah, without perhaps looking at the cultural aspects of organisations and looking at what can be learnt from them, it's more about observing the bad.

Q. You tell us in your statement that the first step to change is understanding the organisation. How do you go about doing that in a real world way?
A. Look, the approach that I take is usually looking at the history of an organisation, looking at how many times - like, typically when someone's looking at the culture of an organisation it's usually not the first time and there's been many attempts before that to try to rectify certain

things, and government organisations in particular are good at accepting recommendations but not necessarily seeing them all through, so usually I go back and look at all the recommendations and why they may not have been implemented in the first place and what the barriers to that change might be.

Q. Are you able to offer some observations around common barriers and before you do that I just want to give you a context to my question, and that really is around the Ashley Youth Detention Centre which this Commission has heard evidence about, and it has heard evidence of repeated ongoing reviews into culture and operations at that facility. You obviously haven't examined those and I don't seek your view about that, but what are the common barriers that you find get in the way of long-term systemic change?
A. So, the one really is a lack of structural change. So, if you don't change the - you know, everything from policies, procedures, even physical locations of buildings; if there isn't, like, structural change, then an organisation will default back to exactly how it was, maybe a little bit changed, but pretty much how it was beforehand unless there are things that really make it very difficult to do so.

Q. What kind of things can make it difficult to snap back?
A. Well, so certainly things like legislative change, you know, creating a really robust complaints management system, those things that really change the way people have to do things in an organisation. Even things like career management or promotions procedures, those kind of things; that's what creates change, not coming up with a new mission statement or values or, you know, or even a really passionate leader, yeah.

Q. Can I pause and ask you about that. Is a passionate leader part of the answer but not all of it, or where does that fit in, having a passionate, committed leader who wants to bring about change?
A. I think they are less influential than structural - than making actual structural change. So, a passionate leader, you know, leaders come and go and, unless you are able to sort of sustain that leadership for over a long period of time, and I'm talking about a decade or more, then things can be undermined pretty quickly, people can wait out a particular leader of an organisation, yeah, so

you have to have ways that fix that change that is independent of whoever's in charge.

Q. You speak in your statement about alternatives to the culture analysis that you discussed, and you identify a number of factors that can drive organisational change separate to this catch-all of culture. Can you give us some examples of what you mean when you talk about organisational climate, including microclimates?
A. So, where culture might be an umbrella term that looks at the whole organisation, the climate - climate is far more at a lower level, say, if you think about the climate of your workplace which is really heavily dependent on the leader, so your immediate supervisor: their attitudes, their belief systems, so that feeling of when, you know, you might get a new boss or a colleague who's antagonised you or been gaslighting you or something might leave, you can feel that quite immediately almost, so that's what climate is, it's that much lower level that really can change dependent on who the person is running the place.

Research really shows that you can measure that much better than you can measure culture. So, you can measure climate in a way that can demonstrate how conducive a workplace might be to misconduct happening. For example, if you found that there were a lot of misogynistic attitudes, or you had someone who, I don't know, might have a particular attitude towards certain groups of people, you can tell that people will look at that and follow that, so there's this concept of toxic leadership but also toxic followership, and people can unquestionably follow that and that can be measured at that level. So, I think that's far more useful because quite often that's not the whole organisation that's problematic, it just can be small areas.

MS BENNETT: I think President Neave has a question for you.

PRESIDENT NEAVE: Q. This is very interesting. I wondered whether you do that by surveys or by observation or by some combination of the two? I mean, I can imagine that you might sit in a particular area of an organisation and just watch the interactions, a bit like an anthropologist in a way; that's one way you could do it. I suppose another way you could do it would be by asking people questions about how they feel about their workplace,

but I'm just interested in finding out how you actually do it.
A. Yeah, so typically it can be qualitative and quantitative, so there's - but there are just some really well validated, exceptional tools out there, so survey instruments. And, my bias is towards more observation and qualitative research, but there are some, like, really fantastic survey tools that can be used quite often, like repeatedly, that can assess something called psychosocial safety, and so, really understanding how safe that workplace is, how safe it is to speak up, how safe it is use a complaints management system, how safe it is to be yourself no matter what that self might be; that's the kind of thing that it identifies and it assesses.

Q. So, just thinking about some of the contexts we've examined. You might take a particular section of a Health organisation, for example, and you might do some of those things, and you might see if they changed over time; that would be, presumably, something that could be done in an organisation which has demonstrated failures in the past. That would be a way of looking at whether it's improving or staying the same; have I got that right, have I understood that correctly?
A. Yes, and in a way it can pick up changes that perhaps can't - if you're trying to measure culture, which I believe takes probably 5 to 10 years to occur, like, that big whole of organisational level, measure of climate can be done much more regularly and really show you the results of the people who are based in leadership positions and how suited they are or how aligned they are with the change that you're trying to create.

COMMISSIONER BROMFIELD: Q. Ms Crompvoets, please correct me if I'm wrong on this because it's a recollection, but it's my understanding that the psychosocial safety climate tools have been used, and that there's now databases that means that you can compare the psychosocial safety climate across different organisations and it can also be used to identify within a large organisation where you might have climates that are quite troubling and therefore be used to inform remedial action; is that your understanding of the way in which those tools are used?
A. So, I can't think of a database that sort of benchmarks. I know that there are certain survey instruments out there that do that; I can't think off the

top of my head one. So, I know that there's one that the Australian Army and perhaps more broadly across the Defence Force use that measures certain things and that they can compare themselves to thousands of organisations on a range of different variables, and that's quite useful, because I think that's also one of the things that is problematic when trying to measure culture, is that you've got nothing to compare it to, so it's a bit vague - it can be. Because every organisation, you know, usually claims that they're quite unique or their culture is unique and so it can't be compared, yeah, but that's not necessarily helpful.

COMMISSIONER BROMFIELD: Thank you.

MS BENNETT: Q. Dr Crompvoets, you mentioned before about toxic leadership and toxic followers and one giving rise to the other and I take it, it feeds itself in a bit of a cycle. How deliberate or conscious does that need to be? Can that evolve unconsciously?
A. Yeah, it can. I think there can be different people - it can be types of people who, you know, don't want conflict, they want to be seen by their boss to do a good thing or, you know, to be performing well and that might be unquestionably following them, and then there can be others who look up to that person as a role model and see how well they've done in their career, and so, then copy that behaviour, and that can be definitely unconscious.

Q. You speak in your statement around networks and the formal or informal, the visible and the invisible networks and how that influences the way that the organisation operates. Can you tell us about how that works in perhaps a small State environment?
A. Yeah, so I think quite often in organisations there can be pre-existing relationships amongst people, the way people socialise. You know, perhaps I'd like to think in the past how decisions get made on - I don't know, the stereotype is on the golf course or after work drinks, and those relationships, again, they can have more influence than change programs, because again, they're those things that hold certain behaviours in place, and I think the smaller the State, the more prominent that can be perhaps.

Q. So, I guess, the more prevalent the informal networks, the more scope there is for that kind of influence to be felt; is that a fair summary?
A. Yes.

Q. You also talk about power and the way that it exists and operates in a structure and I wanted to read this sentence from your statement at paragraph 35. You say:

> *To change culture you need to change the rules that dictate the distribution of power.*

Can you tell the Commissioners what you mean by that?
A. Yeah. Okay, so to give an example, you might in an organisation promote a whole lot of women, right, because that's the thing to do, but unless you promote them into positions of power, so where they can have decision-making power around resources, or bigger strategic decisions and they really have a seat at the table where decisions are made, then you're really not challenging those power dynamics; because, as we know - well, as research shows, it's the people in power who are able to do those things; it's not necessarily about the position but it's about, yeah, their decision-making ability.

Q. So, what's the difference between having a promotion and having power? Aren't you higher up the food chain and so you have more power?
A. You would assume so, but that's not always the case. Yeah, so if I look back at my work on Defence as an example, you know, many people can be promoted to Major General level, but there are maybe six of - let's say 15 Major General positions that actually have far more power and far more decision-making ability.

Q. You say in your statement, again reading now from paragraph 37, the organisation, and I think you're referring here to the Australian Defence Force:

> *The organisation realised it could not achieve cultural change if it kept leaders with low emotional intelligence in positions of power despite their success on the battlefield.*

Is that an observation that generalises outside the military?
A. Yes, it is. I think, if you know where you want your organisation to be, you have to choose people - you have to promote people who are aligned with the behaviours that you

want to see, and I think organisations are realising that that doesn't necessarily mean how you behave just in the workplace, it's much broader than that.

Q. Perhaps it's a similar point, but you say further on at paragraph 38 that:

> *[Where] misconduct will be facilitated by the section of employees who are receptive to engaging in wrongdoing or who are susceptible to social influences.*

Is that the flipside of what you're talking about when you talk about informal power, this receptivity to wrongdoing. What do you mean by that?
A. Yeah, so I'm talking about influence there. You can have people who are far lower down the organisational hierarchy but who are charismatic leaders, who are influential, who have a profile that means that they are leaders. And your second point --

Q. Well, what's the relevance really, how have people in that situation affected the culture in an organisation, that receptivity to wrongdoing?
A. Because they can undermine everything that the organisation is trying to do in terms of change if they don't like it, yeah, and there are - yeah, sorry, I'll stop there.

Q. No, no, I'd love an example. Is that, for example, a person who at the back of a classroom in sexual harassment training is rolling their eyes?
A. Yes. Yes, that's a good example.

Q. And so, even when you're trying to roll out, they present a barrier to a cultural change because they're not invested or engaged in it; is that where you're going there?
A. Yes. So, where they might then try to influence others to join them in that sort of - that same behaviour of just undermining it, that this is - you know, this is political correctness gone crazy, this is whatever the off-the-cuff comment might be, and what that does, even though we know, you know, it's kind of flawed logic, it does sort of short-circuit the conversation and discussion, and then a lot of time is spent trying to, you know, bring that person into the tent and get them to see why it's so

important, but a lot of time, when in my opinion they probably should just - they no longer fit with where the organisation is headed and perhaps should no longer be there.

MS BENNETT: I'm sorry, President Neave.

PRESIDENT NEAVE: Q. Just as one example, I suppose, that you might comment on. We've heard that there were sort of two cultures in the Youth - and I use that word loosely, and not in the precise way in which you're using it - in the Youth Detention Centre; so, there were the psychologists and the people that believed that children should be treated in a particular way, and then there were another group that came very much from a custodial perspective, you know, a prison officer perspective in effect, and then new people would come into that Youth Detention Centre perhaps initially being quite supportive of different ways of doing things and then they would be sort of socialised into looking at this as a custodial issue; is that sort of an example and how would you tackle it?
A. So, I think that one of the key times when I think an organisation is really vulnerable when they're trying to create change is, you know, what is that sort of on-boarding or induction experience, and I mean that in sort of, not just a formal induction experience, but what is that experience when they walk through the door, and when you start a new job, you know, you want to fit in, you're looking for indicators for what's normal and not.

And there's a lot of research in hospital settings where this happens, where people come in, they see the way that things are working and they just sort of follow suit without really critically questioning why things are the way that they are, and one way to address that is, once people have been in an organisation for a little bit of time is to almost do, not quite an exit interview, but do an interview with them to talk to them about what surprised them, you know, what did they expect that hasn't quite turned out to what they thought; or yeah, there's different ways to sort of tease that out and capture where - and it's really important, because often we look at the cultural problems being the barrier is sort of at middle management or it's the leader, it may not be the people just to have started, but actually they're positioned in a way where they can just perpetuate some of those really bad

behaviours, unknowingly, yeah, if they're not given opportunities to really reflect on it.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. Doctor, you say in your statement, you talk about the importance of tangible accountability. Can you tell us why tangible accountability is important and what tangible adds to accountability?
A. So, when I look at, say, review recommendations, they can often be sort of vague in terms of, who is actually responsible for this being implemented or this change to occur. So, by tangible I mean a name; a name, like, someone has to have sort of skin in the game, you know, because otherwise there's this diffusion of accountability, no-one is accountable; again, you hear this culture of no accountability, a culture of resistance; like, you need to have someone's name, like, there needs to be people responsible, otherwise, you know, it can get quite blurred.

Q. You talk about a tick and flick mentality in relation to implementation, are we to take from that you mean - well, what do you mean by that?
A. So, I think often when, and again, I'll just give you the example of a review. So, a review recommendation's come out: usually there's sort of this pattern that occurs, particularly if they are public. Out come the recommendations, the leader of the organisation will often unquestionably, or it seems unquestionably, accept everything because they're sort of, you know, in the wrong, and then they go through, yep, doing bits and pieces and ticking and flicking but there's not necessarily - so there's a lot of work that really needs to happen at that point. You need to work out, how are you going to evaluate that recommendation and whether implementing it actually created change, how will you know? You have to be able to measure that. So, if it's just things like, you know - oh, there's plenty of examples out there of really badly articulated recommendations that, you know, you wouldn't necessarily know if they were implemented or not because they're too high level.

Q. The department should consider reviewing the policies and procedures that relate to this issue, for example?
A. That's right, or that the - yes, the organisation should consider looking at the culture.

COMMISSIONER BROMFIELD: Q. Ms Crompvoets, would you think that there was a higher risk - perhaps I'll word it differently. Should organisations be more aware of the risk of a tick and flick approach if there's been an announcement prior to the recommendations being handed down that they are all going to be accepted?
A. I think that it's important for people who are giving recommendations to build in a monitoring and evaluation part of it; like, there has to be sort of recourse to - you know, you have to sort of hold them to more than just accepting the recommendations, you want to put some more substance around it I think, yeah. So, if you say, yeah, we want to come back every year.

You know, in New Zealand at the moment their Auditor-General at the Department of the Auditor is doing a 20-year monitoring and evaluation piece of work for their New Zealand Army; they're going in every two years to audit that change. That's probably the best example I've seen where they've really committed to measuring it.

Otherwise, what happens is in, say, two to three years after those recommendations come out and issues start to bubble up again and there's another review, and more recommendations, and no-one really understands what happened to the initial ones

MS BENNETT: Q. You identify in your statement three categories of employees in an organisation or members of an organisation: the enthusiastic early adopters, those who wait and see before responding, and those who will never get on board. How does an organisation deal with the fact that there are some people who are never going to get on board with some of the changes that need to happen?
A. My take on that is that they no longer fit with the organisation. And, I understand that for some organisations that means losing corporate knowledge, you know, but I think there are compromises that have to occur and if those people - I just think there's an exceptionally large amount of money and resources often spent dealing with the backlash from parts of an organisation where those people are never going to come on board, they are only going to further undermine the work that you're going to do, and the reality is, they no longer fit.

Q. I'd like to identify with you other common mistakes that come up in your work as organisations try and

transition, and you make some observations about this in your statement from paragraph 55 and following, but what are the key mistakes that organisations make when they're trying to transition?
A. Well, not assessing whether or not they're going to create structural change, and not understanding - not really having a theory of change. So, not saying, okay, if we do A then B will happen, and then C will happen and then that will get us to here, so if C doesn't work, well that doesn't mean that you're going to get to that change outcome, so really understanding how these different things that you're going to implement - like, what effect they're going to have and how they relate. So, that's one.

I think not really critically questioning or analysing the recommendations, and sometimes recommendations for change are not articulated in the same language that that organisation might use.

Also I think - well, certainly I've learned that, you know, I might be doing reviews and I'm writing recommendations to a certain level, the people who engaged me, you know, the top of the organisation : the people that are actually responsible for implementing them are often way down that organisational change - you know, organisational chart - and there's some education and training requirements, I think, to - yeah, to help them with that implementation, so that can often be why things sort of fall apart, because you get people at a low level trying to do really complex change, and that can be difficult.

And one of the other mistakes, I think, is - and for all the good reasons why having independent people review an organisation, you know, that's really good and important, but sometimes it means that when that organisation who has reviewed the leaves, you know, there goes all the knowledge with them. So, that sort of knowledge transfer is really important to get people on board to understand actually what was learnt, yeah, I think that's really important and can be a mistake if, yeah, the knowledge walks out the door with the consultants or whoever did the work.

Q. You make a really interesting observation in your statement about the failure to recognise the importance of symbolism, and you give an example about your experience

with the Chief of the Navy. Can you tell the Commissioners about the importance of symbolism and sustainable change?
A. Yeah, so that example was, yep, the Chief of Defence Force, and I think it's looking at those sort of signs and symbols in your workplace that reinforce certain attitudes or behaviours.

So, you know, the example I gave in my statement where the Chief of Defence Force changed out all the rows, you know, probably 30 pictures of white men who had been previous Chiefs of Defence Force and Ministers and changed them with - you know, put up a huge piece of beautiful Indigenous art instead; I think that symbolism, you're not walking in as a woman and not seeing yourself, you know, sort of not reflected in the history of the organisation and not creating a sense of belonging, and that can even be in people's offices, the things that you display, and how an organisation displays its history is often, you know, a key symbol, but there can be others.

Q. It ties into what you talk about in your statement at paragraph 51 about micro changes, and you give an example there of Rio Tinto's instruction of below the line behaviours in meeting rooms, why is that a significant example, or why is that an example that you cite?
A. So, I think there's a tendency with organisational change programs to be big; big, overarching, you know, that involves culture change merchandise in a way, value statements and posters and all that stuff, which is good, but really how much does that affect change? Apart from, you know, creating awareness that there is a change program occurring, it doesn't do much more than that.

The example I gave with Rio Tinto and a couple of examples there were just these small things that introduce certain behaviours sort of as an everyday practice. So, the Rio Tinto one was some time ago when they were perhaps leading the way with some culture change, but they were looking at work health safety; and every meeting, whether it's a meeting of cleaners or it's a meeting of the people at the top of the organisation, they all have to start that meeting with a safety share talking about something they've seen, whether it was outside the organisation or inside that was not safe, and in that way just that language and that - you know, it was important to the organisation and every single person then knew it was important.

Q. You talk as well about the importance of simplicity. Why is it important that the changes be simple?
A. Because change is hard anyway. Change is complex, and I believe that you're better off choosing two or three things to change and change them really well, than 4,000 recommendations and off the organisation goes. You know, it's almost like just choosing some things that they can do well, or choosing things that can be changed that can be achieved and then move onto the next things.

I know that's not necessarily how recommendations and reviews work; you want to be like, here it all is. But change is complex, and so, choosing what you do and making sure that it's written for the right - or it's created for the right audience, yeah, there's a whole range of things that can make it a much more simplified process.

Q. This Commission's been hearing about, for example, a multi-year project to reform Youth Detention in Tasmania, and it seems that the scale of that task is significant. Does that need to be broken down into small steps or do you operate by having overarching change goals with small achievable steps within it?
A. I think you have - it's having that, yes, change goals, so having a sort of underpinning theory of change: this is where we want to get to in 2 years, 5 years, 10 years. But what I've found working with organisations is, they can very quickly become overwhelmed with the amount of change and work that has to occur, and so, you want to help them not just by pointing out what needs to change but framing it in a way that is achievable.

So, yeah, because it is overwhelming, particularly when it needs to be so holistic, and again, that is where people get fatigued within the organisation around that change, and too many things changing at once can also undermine that change program, so that's where again you get two to three years down the track and it all kind of falls apart a bit.

Q. And, how do you know when change has been successful?
A. Well, I think there's a couple of ways. There's evaluating it, evaluating the impact of the changes or the initiatives that you're doing. I think you need to talk to people. Because change can take quite a while almost to show up in data, so if you're asking people all the time it can take years, and actually what you expect when an

organisation is going through change is quite a period of flux as some people accept that change, some people pushback, some people try to work out is it really going to change or not, so there is this period where you would expect things to kind of look a bit all over the place, but that is actually a good - that's an indicator that things are changing as people sort of work out how they fit and leave or don't; the kinds of people you're attracting to the organisation and recruiting can be an indicator.

And also asking - in some work that I've done, actually asked people in the organisation how optimistic they were for change. So, at the start they might have said there's no way this is going to work, and then six months on or a year on, even though things are not perhaps fully implemented, there might be this optimism that actually the leaders are walking the talk and, you know, that people's expectations of the workplace change absolutely, and so, you can sort of see that there are indicators of change occurring, yeah, through people's perception of what's okay and what's not.

Q. Just picking up on your optimism there I'd like to ask you the final question that I have for you today and that is about what optimism Tasmania is entitled to have following a Commission of this kind: is change on a significant scale, in your experience, possible?
A. So, it's not always possible I think, honestly - sorry, I'm an eternal optimist, I must say. Sometimes an organisation needs a complete reset, and there are definitely examples across the world where an organisation or a part of an organisation are actually completely shut down and rebuilt from the ground up to be fit for purpose and something that, you know, if what's happened in its history really become, you know, regardless of the change that you do, it is still strongly tied to that history, then it may not ever be able to shake the damage that that history has caused.

MS BENNETT: Commissioners, those are the questions I have for this witness.

COMMISSIONER BROMFIELD: I didn't have any further, thank you.

PRESIDENT NEAVE: Thank you very much and that was very, very interesting evidence and we will certainly be

considering carefully what you've told us. Thank you very much indeed.
A. Thank you. Good luck.

MS BENNETT: Commissioners, I'm in the hands of the Commissioners, if you'd like a short break or to commence some closing observations.

PRESIDENT NEAVE: Yes, thank you, Ms Bennett. You're going to make your closing observations now?

MS BENNETT: If it please the Commission, yes.

Commissioners, we now draw to a close the last of the five days of our scheduled hearings. Over the last five days we have revisited the Ashley Youth Detention Centre and Health hearings, as well as looked into the future. We'd like to now present some brief reflections by which we do not intend to provide an exhaustive summary of findings or recommendations which might be available to you as the work of the Commission continues.

However, Commissioners, we can see that an emerging theme this week is the significant impact on decision-making by senior leaders such as Department Secretaries in relation to protecting children when there is a failure to provide them with accurate and fulsome critical information, and whether or not this contributes to a culture of plausible deniability.

These are serious matters, Commissioners, which will require further consideration by you over the coming months, including as it relates to the individual responsibility of some.

As with all of our hearings, it was important this week that we hear the voice of victim-survivors and seek to learn from their experiences of child sexual abuse in the context of Tasmanian Government institutions.

The Commissioners will recall that yesterday we heard from Mr Robert Boost who endured child sexual abuse by a perpetrator while in primary school. He explained how the perpetrator befriended his family and groomed him. Mr Boost spoke powerfully of the shame, the guilt, and the fear of the perpetrator which stopped him from reporting his abuse while he was a child.

Mr Boost told the Commission about how the abuse had affected his life. He spoke of his distrust of men and institutions and the impact on his role as a father and husband.

Mr Boost explained that since the abuse he had been running away from it to attempt to survive, but every time he tried to run away, like the tortoise and the hare, the tortoise of his childhood sexual abuse would always catch up with him and shroud his life in a black cloud.

Mr Boost shared his experiences of attempting to report his abuse as an adult. He described how he felt people considered he looked sort of strong enough to not go and get abused as if he was responsible in any way for preventing his abuse. As Mr Boost powerfully explained, "Everyone's a kid at some stage".

As with so many of the victim-survivors we have heard from, Mr Boost also looked to the future and the impact this Commission might have. He said that education would assist to prevent abuse and make it easier for victims to complain of their abuse. He said, and I quote :

Parents, teachers and children all need to know about grooming, how it works.

He asked this Commission to concentrate on the safety of children over the feelings of adults when making its recommendations.

We thank Mr Boost and all the victim-survivors who have come forward to share their experiences in the hope that children will be better protected in the future. We pay tribute to their efforts to support the work of this Commission in order to make a difference for others. We also thank victim-survivors' families and supporters for sharing their experiences.

On Wednesday, Commissioners, we concluded our Ashley Youth Detention Centre hearings when we heard from Mr Patrick Ryan, the former Manager at the Detention Centre, and Mr Chris Simcock, the Executive Director Youth Justice Reform.

We explored with Mr Ryan his knowledge and role in a

number of the events we explored in the course of the Ashley hearings, including information about Lester and how, after being the subject of an allegation of child sexual abuse and being purportedly moved to a policy role, it appears he still had contact with children, including potentially the strip-searching of a child. Whether there was minimisation in the understanding of, or subsequent reporting of sexual abuse of Henry, or whether the reporting of those matters was misleading to his superiors.

It also covered the circumstances of how children were isolated or unit-bound in the response to the December 2019 roof incident and whether this approach was contrary to the laws and policies designed to protect Human Rights.

Commissioners, these matters raise serious concerns about conduct, including the conduct of Mr Ryan, which you may wish to consider closely over the coming months.

We also explored Mr Ryan's training and experience in providing a therapeutic approach to Youth Justice and experience with Youth Justice more generally. Mr Simcock is currently responsible for the operation of Ashley and we acknowledge, Commissioners, that he is still very early in his tenure. We explored with him his qualifications relevant to his role and knowledge and experience in therapeutic approaches to Youth Justice and the Child Safe Standards.

Mr Simcock outlined a number of measures he has taken in his short time in the role, including engaging the assistance of the Australian Childhood Foundation to carry out a review of staff safety, therapeutic practices and assessments of young people, and to complete a practice framework for the centre.

Mr Simcock is simultaneously reconsidering and re-developing the training program for staff. He agreed, Commissioners, to report back on these and other reforms in October of this year.

Mr Simcock's evidence about the timing for closing Ashley and opening new facilities was that the timeframes would be very tight, and to some extent dependent upon the final design of the new detention centres.

Notably, there appeared to be limited plans in place

at present to address the concerns identified before this Commission as they relate to Ashley in the short-to-medium term.

Mr Simcock emphasised the need to get it right rather than to rush Ashley's closure. In contrast today, Commissioners, we heard from Professor Ogloff who expressed a concern about taking too much time. Again, these are matters that the Commissioners will no doubt consider further.

On Thursday and Friday we returned to our Health hearings and heard from Dr Stephen Ayre, the former Chief Executive at Launceston General Hospital, which I will refer to as LGH; Mr James Bellinger, the former Health Manager of LGH; Dr Peter Renshaw, Executive Director of Medical Services at LGH, and Ms Kathrine Morgan-Wicks, the Secretary of the Department of Health. This evidence completed our public consideration of how LGH and the Department of Health has responded to allegations of incidents of child sexual abuse with a focus on the responses to Mr Felton, the Duncan family and the many victim-survivors of Griffin.

Looking first to the case study concerning George. In recalling former Chief Executive Dr Ayre to give evidence we learned more about his response when Mr Felton re-engaged with the hospital in the early 2000s as an adult seeking answers. We learned that both Dr Ayre and Dr Renshaw believed Mr Felton was in fact abused in 1989 and that belief was reflected in Dr Ayre's advice to the then Secretary of the department to compensate Mr Felton to assist him with counselling in his home State and to provide an apology.

This position was in contrast to the legal advice received at the time which advised there was no liability to Mr Felton due to limitation periods. Dr Ayre's advice to support Mr Felton was apparently not accepted, although it appears the Secretary at the time did ask for the employment status of George to be followed up.

Commissioners, neither Dr Ayre nor Dr Renshaw could recall any follow-up on the question of George's employment status. The current Secretary, Ms Morgan-Wicks, confirmed that no records could be found to suggest any steps were taken in relation to George's employment in 2005.

As a result, George remained employed at least from time to time within the Tasmanian Health Service until the department became aware of Mr Felton's abuse again in early 2021. It then initiated a Code of Conduct investigation which led to George's employment being terminated over 15 years after Mr Felton as an adult raised the alarm about the risks that George could present.

We also revisited LGH's response to disclosures of sexual assault from Zoe Duncan. This response was led by Dr Peter Renshaw. We heard from Dr Renshaw of the steps he did, and didn't, take when Mr and Mrs Duncan reported their concerns that a doctor at the hospital had abused Zoe.

Dr Renshaw recognised that a complaint made by Ms Duncan in May 2001 was a professional boundary violation which could have been connected with child sexual abuse. Dr Renshaw accepted that he ought to have mandatorily reported the abuse of Zoe Duncan earlier but otherwise appeared, in our submission, by his demeanour and attempted contextualisation of the actions of Dr Tim, to have failed to grasp the gravity of the allegations made by Zoe Duncan.

While we welcome Dr Renshaw's apology for his speculation about whether Zoe Duncan was abused, Commissioners, you may find his evidence demonstrated a lack of insight into his role and the impact of his comments that is astonishing of a person who has held a senior role in a hospital for 35 years. In the context of Dr Renshaw's evidence, it is open to question the LGH's ability to establish and embed a culture of reporting concerns.

Last week we also sought to further clarify what information was known about Griffin, including when and by whom. We focussed last week on the flow of information about Griffin and how it was shared from Tasmania Police, to Dr Renshaw and HR, up to the Chief Executive Mr Daniels, and ultimately the Secretary of the Department of Health.

We heard that there were failures to record and pass on critical information from and between HR Manager Mr Bellinger and Dr Renshaw that was highly relevant to decision-makers in the aftermath of Griffin's stand down and later death. This included critical information that they both held about the risks Griffin had posed and the

potential link between his offending and hospital patients.

It is open to the Commissioners to find that these omissions had the effect of downplaying the hospital's knowledge and compromising its ability to appropriately respond to staff and community concerns.

Mr Bellinger's initial failures to robustly review and analyse information held by the hospital about Griffin, and to recognise where he had a conflict of interest in doing so, may, it is open to you to find, have compromised the accuracy and integrity of the hospital's actions in the aftermath of Griffin's death.

The omission of critical information from briefings to the Secretary was described by her as "horrifying", noting that had she had such information she would have initiated an independent investigation earlier. The failure to provide this critical information in such briefings ultimately affected all future decisions and actions, including the department's response to the Integrity Commission's review of LGH's response to complaints and concerns about Griffin. Ms Morgan-Wicks now considers the department's response, including to the Integrity Commission, to have been misleading and has since corrected it.

A lack of transparency and accountability in the response lead by Dr Renshaw eroded staff and community trust in the LGH's department's response and might, it may be open to the Commissioners to find, invited suspicions of a deliberate cover-up, something both Mr Bellinger and Dr Renshaw deny.

We are conscious, Commissioners, that but for the tenacity of staff and victim-survivors in continuing to raise their concerns leading to this Commission, the substantial failures identified in the flow of critical information would have gone unknown and unaddressed.

Dr Renshaw was not aware of any marked changes to systems and processes at the LGH in response to Mr Griffin's offending, could not identify how he could now be satisfied as to the safety of children at the hospital. While he did not embrace the finding, Dr Renshaw accepted it was open to the Commission to find that the leadership at the hospital was dysfunctional following the death of

Griffin.

While acknowledging there were serious failings in the briefings to her, Ms Morgan-Wicks appropriately recognised that she could have undertaken additional investigations after Griffin's death into whether there might have been undisclosed offending by Griffin. She accepted Mr Daniels' evidence that his failure to undertake such an investigation was a catastrophic failure and took responsibility as Secretary for not requesting it occur earlier. We see this, Commissioners, as a demonstration of accountability.

Ms Morgan-Wicks described her commitment to restoring community trust in Launceston General Hospital, outlining reforms underway to strengthen child safe practices, improve complaint processes and record-keeping, and modernise the hospital's governance. The Commission will be updated on these reforms as they progress.

Commissioners, the two Health days raise serious matters in relation to the conduct of some individuals which you may wish to carefully consider over the coming months.

With the conclusion of the Health hearings this week we sought to focus on the Tasmanian Government's current activities in response to child sexual abuse while drawing in expertise from other jurisdictions where relevant.

In looking to the future and in the context of the recently announced department changes in Tasmania which will see most government functions relating to children and young people consolidated into what we have described as a mega-department, we heard from Ms Taylor.

Ms Taylor provided insight into the experience in South Australia which ultimately disbanded a similarly consolidated department in response to the Nyland Royal Commission into Child Protection. She was frank in offering advice on how to avoid the problems encountered by South Australia, including by ensuring that leadership at all levels have Child Protection expertise, ensuring that all aspects of the department, including Corporate Services, Human Services, commissioning and Legal Services have knowledge and expertise in child protection; that the structure supports close connections to those with

expertise on the ground with children to avoid bureaucratic delays, and that interventions are evidence-based and facilitate genuine collaboration and information sharing.

Mr Bullard will become the Secretary for the new mega-department of Education, Children and Young People as of 1 October 2022 which will comprise some 11,000 staff. In his evidence he reflected on Ms Taylor's evidence about the South Australian experience and acknowledged the challenges ahead.

Mr Bullard particularly reflected on the evidence before the Commission that suggested that children and young people were not always safe in Youth Justice and out-of-home care and committed to making these new functions his priority.

Commissioners, you may be particularly interested in how these reforms progress over the coming months particularly in relation to Ashley and out-of-home care. There is substantial risk that the significant reform required in the out-of-home care context could be overshadowed, Commissioners, by the machinery of government changes in creating a single mega-department.

The Secretary of the Department of Justice, Ms Webster, updated the Commission on the progress of Child and Youth Safe Organisations Framework designed to improve safety within Tasmanian institutions, to strengthen the oversight of complaints, and to facilitate information sharing. She noted that consultations were underway and that a draft Bill was imminent.

Ms Webster also spoke of the generosity of victim-survivors in sharing their painful, difficult and frustrating experiences within the Civil and Criminal Justice System to influence ongoing reform. As Secretaries Morgan-Wicks, Bullard and Webster and Ms Gale each reflected, leadership will be critical in implementing these reforms.

Today we heard from a range of witnesses traversing the way in which Tasmania can emerge from what has been described by Ms Webster as a low point in its journey in addressing child sexual abuse.

Professor Ogloff explored some of the issues any

reform of particular institutions will need to consider, including moving the Youth Justice System from a custodial approach to one that is focused on creating a positive environment and addresses the criminogenic factors underpinning criminal behaviour with an emphasis on rehabilitation and recovery.

Professor Ogloff highlighted the need to prioritise comprehensive health assessments upon intake as a public Health opportunity, the importance of continuity of care, the need for highly trained multidisciplinary teams, and the requirement to immediately address the current unsafe physical space at Ashley and Youth Justice staffing levels and expertise to keep children safe.

We had the benefit of hearing from two Implementation Monitors from Victoria's Royal Commission into Family Violence, Mr Cartwright as the inaugural Monitor and Ms Shuard who currently holds that role. We heard their reflections on their functions and powers, the importance of Monitors to add value and to maintain independence while maintaining productive relationships.

We also took note of their advice that desired outcomes would be apparent in making recommendations to give clarity in implementation.

There was also evidence about the importance of governance structures that support implementation, including clear, collective and individual accountability measures around delivery, and we heard that large-scale reform after a Commission of this kind is indeed achievable.

Dr Crompvoets echoed many of the themes of the Implementation Monitors and many of the themes that have emerged from the evidence that the Commissioners have heard to date, including the importance of achievable change clearly identified with simple steps to implementation, and again, her evidence serves as a means of assisting this Commission to make just such recommendations when it comes time to report.

So, Commissioners, we share the hope that is expressed by the many victim-survivors who have given evidence, their families and supporters, that what will follow from these hearings and in time from this Commission is a meaningful

and tangible change, not just another inquiry.

We acknowledge and express our thanks to the Commissioners for the way in which you have presided over the hearings with care, compassion and rigour.

And finally, Commissioners, as we close the hearing aspect of this Commission of Inquiry we extend our thanks to the lawyers who have represented all parties and the logistical support that's been provided to the Commission in the task it has undertaken to ensure that the evidence of victim-survivors and others, without whom this Commission could not proceed, were heard.

May it please the Commission.

PRESIDENT NEAVE: Thank you, Ms Bennett.

MS BENNETT: My learned friend would like to say something for about 30 seconds, if it please the Commission.

PRESIDENT NEAVE: Yes, of course, Ms Mooney.

MS MOONEY: Yes, thank you, President. The State appreciates the opportunity to speak at the conclusion of the Commission's scheduled hearings.

This moment, however, belongs to those who have given evidence in these proceedings about their lived experience and to those who have come forward to shine a light upon events which have occurred in State institutions, and the moment also belongs to those who have not participated in these hearings, but who also have suffered in state institutional settings.

So, the State really simply acknowledges and defers to the closing observations of Counsel Assisting, Ms Bennett SC.

The State thanks you, Commissioners, and all those who have supported you in your work thus far and for your undertaking in the months to come into completing this Commission of Inquiry. May it please the Commission.

PRESIDENT NEAVE: Thank you, Ms Mooney. I think we'll go straight on.

Today we close eight weeks of the Commission of Inquiry's hearings. As we do so we want to reflect once again on all victim-survivors of child sexual abuse.

We acknowledge both the profound and lasting harm caused by the sexual violation of a child or young person and the hurt and sense of betrayal that is experienced by parents, siblings, family members, friends and supporters when child sexual abuse is not adequately recognised and met with action and empathy.

The Commission was established in recognition of the importance of ensuring the safety of Tasmania's children, to enquire into claims of systemic failures or responses by Tasmanian Government institutions relating to allegations and incidents of child sexual abuse, to identify best practices to protect children against child sexual abuse, and address or alleviate the impact of abuse when it occurs.

The National Royal Commission into Institutional Responses to Child Sexual Abuse made far-reaching recommendations to protect children from abuse, to respond effectively when it occurs, and to support all those who had been affected by it. Tasmania has worked to implement those recommendations, or some of them, but much more remains to be done.

In addition, it's clear from these hearings that there are systemic and cultural issues unique to the State of Tasmania that were not uncovered and addressed by the National Royal Commission recommendations.

Throughout the hearings we have sought to explore the strengths and weaknesses of the various Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings. We have addressed issues in relation to preventing, identifying, reporting and responding to child sexual abuse. We have explored these issues in the Education system, the Out-of-Home Care System, the Health System, particularly the Launceston General Hospital, and the Youth Justice System, in particular the Ashley Youth Detention Centre. We have also explored how victim-survivors can seek justice and accountability under criminal laws or through civil litigation.

The Commission has heard from 165 witnesses who have shared their experience, expertise and insights on these issues, but we've also heard from countless others through submissions, consultations with various communities throughout Tasmania, sessions with Commissioners and other information provided to us which have helped inform our approach to the evidence explored through the hearings and will inform our future work.

We have heard from victim-survivors, their families and people who have consistently advocated for change and reform, sometimes at some personal cost.

We have heard from various state representatives, including the Secretaries of the Department of Premier and Cabinet, Justice, Education, Communities and Health, the Commissioner of Police, the Commissioner for Children and Young People, the Ombudsman who is also the Health Complaints Commissioner and Custodial Inspector, and the CEO of the Integrity Commission.

We have heard from professionals who have demonstrated their commitment to the safety of children, including those who have already identified systemic failings and have been taking action to address them.

We have also heard from experts from within and beyond Tasmania who provided insights into some options as to how things might be done differently.

We hope the Tasmanian Government will continue to draw on this expertise. We consider there is much to learn from both the mistakes made and the successful reforms made elsewhere.

The Commission has heard horrifying evidence about failures in existing systems and cultures. While some of these failures occurred many years ago, others are very recent. Many contemporary failures have been shown to have echoes of or direct links to past failings.

Problems in systems and culture have included, and this is not a comprehensive list, of course, some institutional leaders showing limited concern and curiosity about the risks of abuse, including failing to ask questions about warning signs of abuse. Limited understanding of child sexual abuse and harmful sexual

behaviours. Flawed systems which discouraged children, young people, their families and whistleblowers from coming forward. Failures to hear the voices of people who have already difficulty in being heard, particularly Aboriginal people whose children are overrepresented in Tasmanian institutions. Limited understanding of trauma in children who may be vulnerable or have suffered harm before they were sexually abused. Undue emphasis on prioritising staff and employment processes over children and their safety. Inadequate mechanisms and practice for information sharing and insensitivity to victim-survivors and their families who seek support and redress.

The Commission recently concluded our Youth Justice hearings. In September 2021 the government announced its intention to close the Ashley Youth Detention Centre in 2024. The government has committed to major change to the Youth Justice System, including strengthening the therapeutic facilities and practices and embedding a trauma-informed model of care.

As explored during the Youth Justice hearings, there have been reports of abuse at Ashley Youth Detention Centre as recently as late 2021. Once again, some of this abuse resembles older reports of abuse.

On 6 September 2021, the Premier made a Ministerial statement in relation to the Ashley Youth Detention Centre. The Premier indicated a focus on ensuring all alternatives are explored to ensure detention is truly a last resort and children and young people do not need to be remanded to Ashley Youth Detention Centre.

As explored during the hearings, the Commission is concerned about the State's ability to deliver the proposed reforms within the contemplated timeframes. This is heightened by the fact that many reviews and recommendations were not acted upon in the past.

The Commission is concerned about the immediate safety and wellbeing of children and young people in detention today and until such reforms are implemented.

During the hearings the Executive Director Youth Justice Reform, Department of Communities, indicated that a revised Youth Justice Reform Blueprint and a revised plan for Ashley Youth Detention Centre and keeping children and

young people safe could be provided to the Commission by the end of October. The Commission looks forward to receiving and reviewing this, including the measures that will be implemented in the short-to-medium term.

The Commission notes that the Premier has said on many occasions that while the government will await the Commission's recommendations, it will not wait to take action. The Commission encourages the government to take all appropriate action to manage any immediate risks to the safety and wellbeing of children in Youth Detention.

Counsel Assisting have, without fear or favour, called the witnesses they considered necessary to explore the systemic issues that have failed to protect children from sexual abuse in Tasmanian Government institutions or to provide adequate responses to victim-survivors.

We have heard evidence that responsibility for past failings has not been solely the responsibility of one person, one department, or one government. Rather, we have heard that collectively the Tasmanian Government past and present has failed to adequately prioritise the safety of children and the wellbeing of victim-survivors.

As Tasmania moves forward we hope to see the Tasmanian Government take a holistic and shared approach to addressing these past failings. The Commission will comment in its report on any concerns we identify with emerging future reforms.

As Counsel Assisting have said during these hearings, this is a genuine inquiry. The Commissioners have approached the hearings with an open mind about all matters. During the hearings much new information came to light, some matters have been contested by various witnesses. The Commission will continue to liaise with relevant parties to invite them to provide relevant information and to consider their submissions.

We also invite the State to continue to keep us up-to-date with their current reforms. The Commission will need to carefully consider the totality of the evidence, including evidence which may yet be received, before coming to any conclusions. Of course, the Commission will continue to ensure all parties are provided with procedural fairness.

With the conclusion of the hearings the process from here is one of reflection. The Commission will review and consider all of the information and evidence provided during the hearings, together with the information in submissions, from stakeholder consultations and sessions with the Commissioners, and the extensive literature, documents, data and other research that the Commission has gathered throughout its inquiry. We will use all the information to prepare a report delivering our independent findings and recommendations.

Commissioner Bromfield, Commissioner Benjamin and I would like to take this opportunity to acknowledge and thank all of the victim-survivors of child sexual abuse, their families and their supporters who have contributed to the Commission's processes, whether by appearing as a witness, attending a session with a Commissioner, making a submission or providing us with information.

We acknowledge your experiences. We have heard your voices and your pain and we are committed to making recommendations that will enable meaningful change in Tasmania so that your experiences are not repeated.

We acknowledge and thank each of the witnesses who have appeared at the hearings, both those who volunteered to do so and those who appeared in response to notices to appear. We thank all those witnesses who listened, took responsibility where appropriate, and responded to victim-survivors and who sought to imagine the reforms that would be required to enable children and young people to be safe from harm and to enable them to flourish.

We acknowledge and thank all those who have worked tirelessly to ensure that these hearings have proceeded smoothly and efficiently. We thank the Commission's operations, community engagement and media teams who have delivered hearing facilities against three different locations in Hobart and Launceston and supported witnesses, and the public who have attended the hearings or reached out to the Commission and engaged with the media to facilitate public reporting of the hearings.

We thank the hearing operators and transcriber who have worked very long days to ensure our hearings are successfully live-streamed, and the Commission witnesses,

media and the public have access to records of its proceedings.

We acknowledge and thank our Counsel Assisting and our legal policy and research teams for all the work they've done to structure and deliver these hearings. This has involved considering a vast amount of information, from policy to factual issues, identifying appropriate witnesses and framing questions. The Commissioners have been greatly assisted by this critical work.

We acknowledge counsel and the legal teams who have assisted the State and the various witnesses who have been separately represented throughout the hearings. We are grateful to them for approaching these hearings in accordance with the Commission's preferences to manage the hearings in a trauma-informed way whilst still seeking to ensure procedural fairness.

During these hearings Counsel Assisting have periodically shared the comments of Tasmanian children and young people about their experiences of safety in government institutions. We commissioned research to ensure we heard directly from Tasmanian young people about what makes them feel safe and heard when at school, in hospital, in out-of-home care and in Youth Justice. This research is currently being finalised and will be published to ensure that the voices and views of Tasmanian young people are shared with the wider community.

We're aware that thousands of people across Tasmania and Australia have followed our hearings. Some people have attended in person, others have watched the hearings via the live stream or read the media reports. We thank the Tasmanian community for their interest.

We hope that our hearings have assisted the community to explore some of the issues related to child sexual abuse in institutional contexts as well as the need for change and what some of the opportunities for reform might be.

Our findings and recommendations will be set out in our report which is due to be delivered by 1 May 2023. We encourage the Tasmanian community to continue to expect current and future governments to not just announce but also deliver real change.

We hope to see accountability, transparency and a willingness to learn about how things could be done better. We look to all Tasmanians to continue efforts to ensure the safety of children and young people from sexual abuse after our work has ended. Thank you. We'll now adjourn.

AT 3.40PM THE COMMISSION CONCLUDED