
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 26 August 2022 at 9.34am

(Day 31)

1 PRESIDENT NEAVE: Thank you, Ms Rhodes.

2

3 MS RHODES: Thank you, Commissioners. Our first witness
4 this morning is Ms Alison Grace, she's being interposed
5 before we recommence with Mr Pervan later this morning. If
6 she can be administered the affirmation.

7

8 <ALISON LYN GRACE, affirmed: [9.34am]

9

10 <EXAMINATION BY MS RHODES:

11

12 MS RHODES: Q. Ms Grace, could you please state your
13 full name for the transcript?

14 A. Ms Alison Lyn Grace.

15

16 Q. And your occupation and professional address?

17 A. I am the Deputy Centre Manager at Bimberi Youth
18 Justice Centre in the Australian Capital Territory.

19

20 Q. You've been in that role since about April 2020; is
21 that correct?

22 A. Yeah, I was acting as the Executive Branch Manager
23 from April 2020 till August 2020, and then moved into the
24 Deputy Centre Manager role.

25

26 Q. Prior to that, you've had at least 20 years experience
27 in the Youth Justice space in the ACT?

28 A. Yeah, that's correct.

29

30 Q. You've kindly attached your CV which is very lengthy
31 and very detailed, so I don't mean to embarrass you, but
32 you seem to be very qualified in the area of Youth Justice
33 both starting as a youth worker and then making your way up
34 into policy roles through government and now as a Centre
35 Manager?

36 A. Yes, thank you.

37

38 Q. What is your role as the Deputy Centre Manager?

39 A. As the Deputy Centre Manager I work with the rest of
40 the management team and the team at Bimberi to ensure the
41 safe care and custody of young people who have been
42 remanded in custody or sentenced to a period of detention
43 in the ACT.

44

45 Q. What is the age cohort that comes into Bimberi?

46 A. So, at Bimberi we can have young people as young as
47 the age up 10 up to the age of 21 where the young person

1 has committed an offence prior to the age of 18.

2

3 Q. Before Bimberi there was Quamby?

4 A. That's correct.

5

6 Q. Which was the Youth Detention Centre prior to Bimberi
7 and Bimberi was brought in because there was a change in
8 legislation which had more of a Human Rights focus than
9 what the previous centre did. What was it about the need
10 to change from Quamby to Bimberi to have this Human Rights
11 Framework?

12 A. In 2008 we had new legislation introduced, the
13 Children and Young People's Act. We also had the Human
14 Rights legislation introduced in the ACT around the same
15 time. The focus of Youth Justice in the ACT had moved from
16 a Justice focus to a Community focus, so custody as a last
17 resort, so Quamby was no longer fit for purpose to be able
18 to do that in both the infrastructure and the policies and
19 procedures so there was work done over several years to
20 design and develop a new centre which was Bimberi.

21

22 Q. It's embedded in the legislation, the Human Rights
23 Framework and other legislation. How do you put the Human
24 Rights on paper into practice in a Youth Detention Centre?

25 A. Yeah, so we have worked with our Human Rights
26 Commission and our department to ensure that it's not just
27 on paper and in our legislation but through our recruitment
28 of staff, through our training of our team, and also the
29 work that we do with our oversight agencies to ensure that
30 young people and their families are aware of their rights
31 and their responsibilities, that our team are aware of
32 young people's rights and that our policies and procedures
33 reflect those rights to ensure that young people do have a
34 voice and can speak out.

35

36 Q. So, there's a lot of moving parts there to make sure
37 that the Human Rights Framework is adopted and embedded
38 into a Youth Justice Centre.

39 A. Yep.

40

41 Q. So, I'll just go a bit at a time. You talked about
42 oversight bodies; how are the oversight bodies in the ACT
43 working together to ensure that the Human Rights Framework
44 is embedded and adopted?

45 A. Yeah, so we have a Human Rights Commission, there is a
46 Children and Young People's Commissioner within that who is
47 also the public advocate and she has a team of advocates

1 who are responsible for visiting young people in Bimberi
2 and also for overseeing our registers. We have official
3 visitors who are appointed by the Minister and report to
4 the Minister directly to hear complaints from young people.
5 One of those official visitors is an Aboriginal and Torres
6 Strait Islander person. We have the Office of the
7 Inspector of Correctional Services. We also have the
8 Ombudsman Office who are responsible for Reportable
9 Conduct. So, their roles and responsibilities are
10 different but they're all responsible for ensuring the safe
11 care and custody of young people.
12

13 We work with them both individually and as a group
14 through the Bimberi Oversight Committee to ensure that
15 they're not only looking at the rights of individual young
16 people but also the systemic nature of the centre and how
17 we can work to improve outcomes for young people and ensure
18 their safety.
19

20 Q. It sounds like there's quite a lot of people who have
21 oversight?

22 A. Yep.
23

24 Q. What is the benefit of having them all together in
25 this one meeting that you have?

26 A. Yeah, so the Bimberi Oversight Group allows us to
27 bring oversights together once a quarter to discuss the
28 strategic direction of Bimberi and also any concerns that
29 they might have that are overlapping across their different
30 responsibilities and to share, you know, what's the
31 direction we want the centre and the Youth Justice in the
32 ACT to take and how we can work together to achieve that.
33

34 Q. Has that oversight meeting always been in place or
35 were there points where they were coming in individually?

36 A. No, so that has only been in place for the last
37 few years, and prior to that we just worked with them all
38 individually. And we've had a few extras come in, so
39 Reportable Conduct has come in in the last probably
40 four years I think, and the Office of the Inspector of
41 Correctional Services has been in place for a couple of
42 years, so the additional oversight saw the need to bring
43 everybody together so that we could work most efficiently.
44

45 Q. You talked about the induction process for recruitment
46 and induction also being part of being able to embed the
47 Human Rights Framework. Could you give a brief overview of

1 what the recruitment and induction process is?

2 A. Yeah, so from the very beginning we recruit youth
3 workers and that is to ensure that the people who want to
4 come and work with us do want to work with young people and
5 come from an angle of wanting to ensure their safety and
6 their rehabilitation and re-integration back into the
7 community.

8
9 We run an Assessment Centre which includes
10 psychometric assessment, psychometric interviewing, and
11 health and fitness assessments prior to people being
12 offered an opportunity to come and work with us.

13
14 All staff who are coming in as operational staff need
15 to participate in a seven-week induction program, and
16 through that program we provide all manner of training from
17 our policies and procedures, we have the Human Rights
18 Commission, all of our oversights come in and speak with
19 our new recruits; they go through a range of observation
20 shifts. We have training in trauma-informed care, working
21 with young people with a disability, cultural awareness
22 training, just to ensure that it's not just about policies
23 and procedures but also what are the expectations of staff
24 to work in a trauma-informed therapeutic and responsive
25 manner to the young people.

26
27 Q. You say in your statement at 92, if that would be of
28 help, that you have a principal practitioner who I
29 understand is a clinical psychologist?

30 A. That's correct.

31
32 Q. And is responsible for oversight and supervision of
33 youth workers to ensure that they are applying what they've
34 learned in practice, but as part of their induction or part
35 of their training you say that the person provides training
36 to staff to ensure services are delivered in a
37 trauma-informed and therapeutic way, and that includes
38 training in relation to professional boundaries and
39 self-disclosure, self-care and reliance and working with
40 communities.

41
42 Can you explain to the Commissioners what you mean by
43 self-disclosure and why that's important in this training?

44 A. Yeah, so Canberra is a small place, it's not uncommon
45 for our staff to know young people who are in our care, and
46 so, we make sure staff understand that they have a
47 requirement to let us know if they do know a young person

1 or a young person's family and what that pre-existing
2 relationship might look like so that we can provide them
3 with the support and also ensure the young people - you
4 know, that that relationship is known about and if there's
5 anything we need to put in place.
6

7 So, self-disclosure is also about our staff
8 understanding that we're there to support them and if they
9 do have things going on in their own personal lives that
10 might impact their work at the centre, it's important that
11 we know about them so we can support them with that and
12 that it doesn't impact them when they come to work and
13 their role with the young people.
14

15 Q. You said that there's training by Australian Childhood
16 Foundation; what sort of training do they offer your staff?

17 A. So, the Australian Childhood Foundation come and
18 provide two sessions to our staff: one of those sessions is
19 about working with young people, understanding adolescent
20 development and trauma and working with young people who
21 have a trauma history or also young people with sexualised
22 behaviours, so they provide that training to staff.
23

24 The other training that they provide is training
25 about - that goes more into how you engage with young
26 people who have a trauma history or may have different
27 developmental needs, so it's about how you engage with
28 those young people, how you create professional but
29 mentoring relationships, but also how you then - if a
30 situation is becoming difficult, how you diffuse situations
31 and things you might need to consider for the client group
32 with which we work.
33

34 Q. You also say, at paragraph 132 of your statement, that
35 there's training on mandatory reporting and the Reportable
36 Conduct Scheme?

37 A. That's right.
38

39 Q. With all of this training, this occurs at the
40 induction phase?

41 A. That's right.
42

43 Q. But is there ongoing training on these issues?

44 A. On these topics? Yes, so we have skills maintenance
45 sessions every Tuesday and Sunday morning, we do them twice
46 a week to ensure that we catch both lines of staff, we have
47 two lines of staff. The training provided by the principal

1 practitioner is reiterated through that training, at least
2 a couple of times a year.

3
4 Q. You say two lines of staff, could you just explain
5 what that means?

6 A. Yes, so our youth workers work in two teams, and they
7 work opposite days. So, they do 12-hour shifts two days a
8 week, and then the other team comes on for two days a week,
9 then the first team comes back for three days a week and
10 then the other team comes for three days a week.

11
12 Q. You said that the policies and procedures are designed
13 to be therapeutic. At paragraph 126 of your statement you
14 explain that there is a way of - you have adopted a method
15 of monitoring or supervision that - sorry, I'll rephrase
16 that question. You talk about, that if people aren't
17 following those policies and procedures, there is a way
18 that that's addressed within the centre. Could you explain
19 to the Commissioners what that is?

20 A. Yeah, so we have supervision for staff and that's live
21 supervision and also face-to-face supervision one-on-one
22 with staff. So, through that we can start to address any
23 immediate concerns where we see that a staff member might
24 not be following policies and procedures or we might have
25 concerns about their practice, we can address it through
26 that; and then, if we do have concerns, we can make things
27 more formal and following it up with our People Management
28 Branch.

29
30 Q. I'll come back to that more formal process, but one of
31 the big features of Bimberi to help with the implementation
32 of the Human Rights Framework is the actual physical
33 infrastructure of Bimberi. Could you give a brief outline
34 of what that looks like and how that compared to Quamby?

35 A. Yeah, so Quamby was not initially designed as a Youth
36 Detention Centre, so it was outgrowing its capacity, it did
37 not have the technology that we have at Bimberi, it wasn't
38 designed in a way that would meet Human Rights compliance
39 or the therapeutic requirements of the young people, so
40 investment was made in a new centre and it was
41 purpose-built designed. It was based on a sort of - a
42 school campus model where the community features such as
43 the school, the dining hall, the health facilities, the
44 visitor centre and the spiritual centre are within the
45 central area of the site, with the units on the outside of
46 the centre.

1 The units are smaller in size, so we have wings of
2 four to six young people in each unit, and each unit has -
3 you know, within those four, each young person has their
4 own room with their own ensuite.

5
6 Q. You give detail of the units at paragraph 27 of your
7 statement. Would I be correct in saying that the units
8 have their own bathroom, their own kitchenette, their own
9 living area, so it is very much like a home?

10 A. Yeah, that's right. So, each unit has a duty
11 point for staff but then it's got a common area for the
12 young people that has a small kitchenette, it has a
13 telephone booth where the young people can lock the door
14 and have private conversations with their family and
15 professionals. It has a communal toilet but then within
16 each room there is also a shower and toilet for the young
17 people to have that, and each unit has its own courtyard
18 which is secure.

19
20 Q. In addition to that, they're free to move around the
21 centre quite easily compared to what was in Quamby; is that
22 correct?

23 A. Yeah, besides the courtyard and one basketball court
24 the site at Bimberi is completely open with an external
25 perimeter fence but there is no fencing inside the centre
26 which allows the young people to move around; the movements
27 are controlled by radio and via a control room so we always
28 know where the young people are moving around, but there's
29 no fences or gates within the internal area of the centre.

30
31 Q. How do you see that infrastructure playing into the
32 Human Rights Framework and getting better outcomes for
33 young people?

34 A. Yeah, it's a really nice environment for young people,
35 we use a lot of - there's a lot of bright colours, and
36 also, a lot of people that come and visit Bimberi say, "Oh
37 wow, I didn't expect it to look like a school, it's so open
38 and it doesn't have the feel of a jail", I guess, is what
39 some people expect.

40
41 Q. Another factor of this Human Rights Framework is
42 actually informing the young people of their rights. What
43 is the importance, from your perspective, of young people
44 knowing about their rights?

45 A. Yeah, it's really important that they understand that
46 we are there to support them, that we're there to help them
47 and that we're there to keep them safe. We have a

1 responsibility to the courts to keep them secure within the
2 centre, but beyond that it's about their rehabilitation and
3 their re-integration back into the community.
4

5 So, we make sure that young people are aware that they
6 have rights and minimum living conditions, and that they
7 are free to talk to us about those if they feel that
8 they're not being met, and there's also the ability to
9 complain to our internal complaints processes or through
10 the number of oversights that visit the centre, that they
11 can have a voice and they can speak up if they would like
12 things to change.
13

14 Q. The centre provides that information in a written
15 form?

16 A. Yep.
17

18 Q. But there's other forms that you tell young people
19 about these rights to ensure that they actually do
20 understand them and know them; is that correct?

21 A. Yeah, that's right. So, as part of the induction
22 process we are required to explain to young people their
23 rights and their minimum living conditions. We understand
24 that's a difficult time for young people, it's also often
25 in the middle of the night where they may be impacted by
26 their arrest or by drug and alcohol or, you know, the
27 trauma of being arrested.
28

29 So, over the following few days that they're with us
30 we also provide them with a handbook that has that
31 information in it for them to read on their own. They're
32 also shown a video at induction, but over the days that
33 they're first with us, the staff re-explain that to them
34 and we've got a form that we sort of check off to make sure
35 that we have - a rights and responsibilities form that
36 ensures that we have gone back through all of that
37 information with the young person so they can understand
38 that. And our oversights, our official visitors and our
39 public advocates, they visit regularly, at least
40 fortnightly, and they'll also share that with the young
41 people as well.
42

43 Q. Thank you, I'm just going to move back to the
44 complaints topic. You explain at paragraph 136 of your
45 statement what I'm calling a routine process in relation to
46 incidents. Could you explain what incidents you're looking
47 at and what that process is?

1 A. Yeah, so we have category 1 and category 2 incidents.
2 So, category 1 incidents are those high level incidents
3 such as escape, serious assault, serious self-harm or death
4 in custody. But we also have category 2 incidents which
5 are assault, threats to the safety and security, fights,
6 self-harm, those sort of things, yeah.

7
8 Q. And, once those incidents are known, what steps do you
9 take to investigate those incidents?

10 A. Yep, so all incidents that occur, anybody who was part
11 of that incident or has witnessed that incident is required
12 to write up a statement that staff - and any other person
13 that saw that incident. Young people are offered the
14 opportunity to make a statement as well and we support them
15 in writing that down. From that point we also review any
16 footage that we might have of the incident; that's all
17 compiled into a report that is reviewed by our Operations
18 Manager as part of - if there's young people involved we
19 need to complete a use of force statement if there was a
20 use of force; we need to offer the young person medical,
21 and they can decline that and they have to sign a form if
22 they choose to decline, but they must be offered medical
23 assistance. We report that to our insurance agency to make
24 sure there's a record of what's occurred with the insurance
25 agency, and so all of that information is compiled and goes
26 to the Operations Manager, (1) to ensure that it's all
27 completed as it's required to, including debriefing notes
28 from the debriefing that occurs with staff, and then the
29 information goes to our Executive Branch Manager or who
30 also needs to review all of the information from that
31 incident, look at any recommendations from the Operations
32 Manager or the Unit Managers, and then how we implement any
33 of those changes.

34
35 Q. Part of that process, you explain in your statement,
36 is the - I'm going to get this wrong - but the People
37 & Culture Management Branch; is that right?

38 A. People Management Branch, yes.

39
40 Q. Thank you, People Management Branch are there, so
41 that's you're Human Resources Department?

42 A. Yes.

43
44 Q. They're part of that process in some capacity; is that
45 correct?

46 A. Yeah, so if we see that there is any concerns raised
47 that might relate to misconduct by staff, then we seek the

1 advice of the People Management Branch in, you know, what
2 do we need to do further if we need to look at that matter
3 through the Public Sector Management Act.
4

5 Q. So, the incidents that you talked about go through the
6 process that you said?

7 A. Yep.
8

9 Q. But when there's any allegation about misconduct or
10 inappropriate behaviour by a staff member, the process is
11 different or similar?

12 A. So, the process could be different. So, if the
13 misconduct or the concerns about a staff's behaviour are
14 identified through the incident report, then People
15 Management Branch will have access to that information, but
16 if it is just - it may not come from an incident, it may
17 just be a complaint or an allegation made by somebody, then
18 we will investigate that. We will seek their advice early
19 on to see what we need to do, and if there is any substance
20 to those allegations, then it will be written up and a
21 preliminary assessment completed which is under our EBA,
22 and then seek their advice on where we need to take that
23 further.
24

25 Q. As a centre you do the preliminary --

26 A. Assessment.
27

28 Q. -- assessment, so would that involve the steps that
29 you said in terms of looking at CCTV footage, getting
30 witness statements and speaking to the young person?

31 A. Yes.
32

33 Q. And then you get that information with the assistance
34 of --

35 A. People Management.
36

37 Q. -- People Management, to make sure you've done all the
38 things you need to do to then make that preliminary
39 assessment report?

40 A. Yep.
41

42 Q. And, whatever your decision - is it a recommendation?

43 A. It's recommendations at that point, that's right.
44

45 Q. So, you haven't made a decision yet, you've made a
46 recommendation about whether someone possibly is in breach
47 of the State Services Act?

1 A. Yep.

2

3 Q. And then it goes to the People Management Branch?

4 A. That's right.

5

6 Q. What do the People Management Branch do with that
7 report?

8 A. So they'll look at that report, they'll ask us for any
9 further information that they might think is necessary to
10 that investigation; so they might ask for different footage
11 or, you know, further information on that staff member, so
12 we'll provide them with whatever information they need and
13 then they will make decisions based on that. So, it might
14 finish at that point where there might be no
15 substantiations of anything, or it could be, if there is,
16 then they'll make recommendations under the Public Sector
17 Management Act under, you know, counselling for the staff
18 member or further extension of their probation if they're
19 still within that first three months of their employment,
20 or they might refer it on to the Chief Minister's area who
21 have an investigation branch and will investigate further.

22

23 Q. Just going back slightly. With the preliminary
24 assessment that you do, how long does that process usually
25 take?

26 A. It will depend on the incident. So, it may need to be
27 done very quickly depending on the serious nature of the
28 incident or how - you know, if something's very clear then
29 it can be done very quickly, or it might take several days
30 to weeks to complete.

31

32 Q. But we're not looking at longer timeframes like months
33 or years to complete a preliminary assessment?

34 A. No, a preliminary assessment is just that initial
35 gathering of information to see that there is possibly
36 something there, and then it goes on further, so it's just,
37 is their basis there, is there something there but it's not
38 the full investigation.

39

40 Q. You said that if it's something significant the People
41 Management Branch would refer it to the Chief Minister's
42 Investigation Team.

43 A. Yep.

44

45 Q. What is that Investigation Team? Is it a specialist
46 team just for your area?

47 A. No, so that's across the ACT Government. So, they are

1 the ones that are responsible for then looking at it
2 further and under the Public Sector Management Act and
3 determining if that person has actually breached their
4 requirements under the legislation for their employment as
5 a public servant.

6
7 Q. So it's a specialist team for whole-of-government?

8 A. That's right.

9
10 Q. That deals with disciplinary matters?

11 A. Yes.

12
13 Q. Investigating those disciplinary matters?

14 A. That's right.

15
16 Q. And, once they've investigated, are there any other
17 referrals beyond that? Where does it go from there once
18 they've done their investigation?

19 A. Once they've done their investigation I don't think
20 there are any - I think that a person can appeal it if they
21 feel that they've been, you know, wrongly named in
22 something, but that we'll make a decision based on their
23 employment with the ACT Government.

24
25 Q. As a Deputy Manager of the centre, what reporting
26 obligations do you have to other organisations like police
27 or Ombudsman or something?

28 A. Yeah, so I'm a mandatory reporter, all our staff are;
29 that means that any child sexual abuse we need to report,
30 or physical abuse we need to report to Child and Youth
31 Protection Services. In the ACT we're also required to
32 report that to the police, and if it has to do with a
33 person's conduct within the workplace and it meets the
34 threshold for an allegation under the Reportable Conduct
35 Scheme, that needs to be reported to the ACT Ombudsman's
36 Office, so we do that through our People Management Branch;
37 we share with them and then they ensure that the
38 appropriate paperwork is done and the information's shared
39 with the Ombudsman's Office.

40
41 Q. Whilst this whole process is being conducted from when
42 you start your involvement in your preliminary assessment,
43 what has happened to that staff member who's faced with
44 that allegation?

45 A. That will depend on the nature of the allegation and
46 the advice from the People Management Branch. If there are
47 concerns about a young person's safety or the treatment of

1 that staff member and we're looking into that further, they
2 might be removed from working with young people and moved
3 into another position with us or within the Directorate;
4 they might be stood down pending that investigation outcome
5 as well; so, might be dismissed quite quickly.
6

7 Q. If there was an allegation of child sexual abuse at
8 the centre, would it be an expectation that that staff
9 member who the allegation is about would be stood down
10 until that investigation is completed?

11 A. Yes.

12
13 Q. You provide an example, at paragraph 130 of your
14 statement, in relation to your own personal experience with
15 dealing with a sexual allegation.

16 A. Yep.

17
18 Q. Could you explain to the Commissioners what happened
19 in that circumstance?

20 A. Yeah, so I was made aware that a staff member, a
21 non-operational staff member, may or may not have formed a
22 relationship with a young person outside of Bimberi. We
23 reported that immediately to the People Management Branch
24 and started to look at the evidence available to us through
25 CCTV within the centre to see if there were any concerns
26 about the interactions of those two people while the young
27 person was in our care and all of that information was
28 shared.

29
30 It was evident that nothing had occurred while the
31 young person was at the centre, but obviously information
32 had been shared between the young person and the adult that
33 allowed the adult to contact the young person in the
34 community. So, that information was shared with People
35 Management Branch who came in and the staff member was
36 stood down pending that; they were on contract, so then
37 their contract was ended immediately pending further
38 investigations.

39
40 Information was passed on to the ACT Ombudsman as a
41 Reportable Conduct matter and also passed on to the police
42 for investigation in case there was other information or
43 evidence available to them that we weren't aware of that
44 might have meant that adult was having inappropriate
45 relationships with young people in the community.

46
47 Q. When you heard that allegation you took it at its

1 highest?

2 A. That's right, yep.

3

4 Q. And during the investigation - these are my words, not
5 yours --

6 A. Yeah, that's okay.

7

8 Q. -- it wasn't as grave as you originally thought in
9 terms of the intimate nature of the relationship?

10 A. Yeah, that's right.

11

12 Q. But he was still stood down and contract terminated
13 because you as an organisation took the allegation
14 seriously and recognised it as professional boundary
15 breach; is that correct?

16 A. Yeah, that's right. There was definitely concerns
17 with the professional boundaries and so that was - you
18 know, we knew that that had happened, that the person
19 hadn't acted under the Public Sector Management Act and
20 maintained the boundaries that they needed to hold as a
21 professional, but we believed that was the extent of it.

22

23 Q. When someone is stood down from their position whilst
24 these investigations are going, how does that affect your
25 staffing levels and how do you cope with removing someone,
26 if it is an operational staff member, how do you cope with
27 losing a team member?

28 A. Yeah, we have pretty good staffing levels, so we do
29 bi-annual recruitment to try and ensure that we always do
30 have enough staff, but you know, there are a lot of things
31 play into your staffing levels: there could be staff that
32 are under investigation, we have staff that are often on
33 return to work because they may have injured themselves in
34 the workplace, mostly through sporting injuries, and also
35 staff need to be given their opportunity to have their
36 personal and their annual leave as well, so we need to
37 manage that as best we can.

38

39 So, we risk assess each day to ensure that we have
40 enough staff to safely operate the centre. We have a
41 casual pool of staff that we call in if we require
42 additional staff, we offer staff overtime if we need to but
43 we can go into our business continuity which is to have
44 lunchtime lockdowns or rolling lockdowns if necessary.

45

46 Q. Having a stand down and going through the process of -
47 a disciplinary process obviously has an industrial

1 relations implication or employment issue. In your
2 experience, where's the balance between the industrial
3 relations issues and the safety of children in your
4 organisation?

5 A. In?

6

7 Q. Sorry --

8 A. Yeah, you want me to explain a little bit?

9

10 Q. Sure. So, you are caring for the children?

11 A. Yeah, that's right.

12

13 Q. So your focus is the safety of the children. Do
14 industrial relations issues play into any of your
15 decision-making when you're going through the assessment of
16 whether the allegation is true or not?

17 A. No, if there's an allegation then, you know, that
18 needs to be addressed; it's not about, we'll take other
19 measures to ensure - you know, we need to make sure the
20 staff are safe as well, so if that means we need to put
21 other measures in place such as lockdowns because our staff
22 numbers are too low, then that's what we'll do; we won't
23 keep staff working if we're concerned about their behaviour
24 and the way in which they're acting with young people.

25

26 Q. The Commission has been looking at harmful sexual
27 behaviours between detainees, and you explained that with
28 the training there's the Australian Childhood Foundation
29 that talk about these behaviours?

30 A. Yep.

31

32 Q. What steps do you take in Bimberi to keep kids safe
33 where there are allegations of harmful sexual behaviours,
34 if that has occurred in Bimberi?

35 A. Yeah, it's not - we don't often see young people with
36 either coming to stay with us because of an alleged sexual
37 offence or a proven sexual offence, and we don't see many
38 young people that do have any harmful sexual behaviours; I
39 can't think of any in the last two years that I've been
40 back at the centre. However, there are advantages of being
41 a small centre and that means that we can put a plan around
42 that young person to keep other young people safe and them
43 safe, so we will work with our colleagues in Child and
44 Youth Protection Services, in Justice Health Services, our
45 Education team and our principal practitioner to ensure
46 that we have, you know, a plan in place to keep that young
47 person and the other young people safe as well.

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Q. You've got education staff who are managed by Department of Education?

A. That's right.

Q. You've got a Health Team that's managed by the Health Department?

A. That's right.

Q. And then your Operations Team who are under - some are under the Communities --

A. Yes, so where all the Community Services Directorate, our Operational Team, Management Team were the Community Services Directorate, and our case managers are as well, but they don't work on site at Bimberi, they work across Child and Youth Protection Services.

Q. There's multiple agencies working here; how do you work together to ensure that decisions are being made in the best interests of children?

A. Yeah, so we have written within our legislations the requirements of the Health Team and a Memorandum of Understanding with them. We have procedures in place with Education for that. We also have a single case management framework that provides the requirements and how we work with our Case Management Team who are in the broader Community Services Directorate, and we have a client services meeting that brings all of those parties together each week to discuss each individual or young person, how they're going in Bimberi, what's their plans for transition out of Bimberi, where there's any concerns and where's the best service to address those concerns or, you know, what needs to be put in place for them and who can do that best, and so, each young person is discussed within their first week in our care and then at least monthly.

Q. Just one final question. You said at the beginning that Quamby wasn't fit for purpose to fully implement this Human Rights Framework. How was it that ACT was able to move from what was happening at Quamby to Bimberi?

A. Yeah, I think it was a whole range of things; it was, you know, building a new purpose-built facility was part of that, the change in our legislation, but then also the way in which we recruit and train our staff and that professional expectation for them. We introduced a supervision framework that allows them to be provided with that supervision, both individually and as a team through

1 skills maintenance sessions, and so, it was that whole
2 range of things put together, and just creating a service
3 that was more open and transparent, ensuring that we have
4 our oversight agencies that then other services come in to
5 work with those young people and support them.
6

7 MS RHODES: Thank you, that's the end of my questions.
8 Commissioners, is there anything?
9

10 COMMISSIONER BENJAMIN: Q. I've got a couple of
11 questions, if I may. As you know, I visited Bimberi
12 earlier this year. It's quite an open campus-style
13 facility, isn't it, once you get inside?

14 A. It is, yes.
15

16 Q. My understanding is that the management of Bimberi
17 have broader engagement; you attend conferences with other
18 managements from other centres around Australia and that's
19 a regular occurrence?

20 A. Yeah, that's right, so we're part of the Australasian
21 Youth Justice Administrators.
22

23 Q. And is that to ascertain what others are doing to
24 inform your practices?

25 A. Yeah, that's right. So, we work with our colleagues
26 across Australia and New Zealand. The Australasian Youth
27 Justice Administrators come together twice a year, they
28 also meet via AVL several times a year. There's also a
29 meeting for detention centre managers, so that's occurring
30 in Queensland later this year, and we come together and
31 share information; we also do that out of session, so
32 there's a Secretariat for that group that will pass
33 questions between jurisdictions and where we can we will
34 share our policies, our procedures, you know, what's
35 working for us and what isn't working for us across and
36 between those jurisdictions and New Zealand.
37

38 Q. Thank you. I think you in your statement say you have
39 capacity for 40 beds but you're funded for 21?

40 A. Correct.
41

42 Q. And that in each of the units you might have, you
43 generally have one set of rooms which are adjoining
44 generally for Aboriginal and Torres Strait Islander
45 children or siblings who are close to each and where it's
46 appropriate?
47

A. Yeah, correct.

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Q. My recollection is they haven't been used in that form so far?

A. No, they haven't been used in the time that I've been there.

Q. You also said at one stage during your evidence that, if there's a category 1 or a category 2 incident, the staff debrief after.

A. Correct.

Q. Is that debriefing for the mental health of the staff but also to see what happened and what can be done about that in the future?

A. Yeah, that's right. So, we do secure the young people following those incidents so that we can bring the staff that were involved in the incident together and talk through what they - you know, the role they each played in that incident, what they thought went well, what they thought could be improved, any concerns that they had, and that's usually run by one of our Unit Managers, and then also to ensure that everybody - that there's no injuries to the staff, that there are no welfare concerns for the staff; staff are reminded of their opportunity to come and speak with a member of the Management Team if they've got any concerns and also that the Employee Assistance Program is available to them.

Q. You have both young people, that's the 18 to 21-year-olds and the children that are 10 to 17 there.

A. Yes.

Q. Are they debriefed or provided with support after incidents such as that?

A. Yeah, so our young people involved in the incident are offered the opportunity to see a Health professional, whether that be the nurse, the doctor or psychologist, and they're also offered the opportunity to make a witness statement and talk about their involvement.

Q. Finally, you gave a list of people who come in with whom you engage; I think you also have someone from OPCAT, the Optional Convention Against Torture; is that correct?

A. So, the OPCAT is just starting to be implemented in the ACT, so that's being overseen by the Office of the Inspector for Correctional Services and the Human Rights Commission.

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Q. So it's one office being - or that office is being shared by somebody who's already involved in the process?

A. Yeah, so the Office of the Inspector of Correctional Services and the Human Rights Commission will be looking after OPCAT within the ACT.

COMMISSIONER BENJAMIN: Thank you.

COMMISSIONER BROMFIELD: Q. I just had a couple, I'll be quick. I just wanted to confirm that, in addition to CCTV, you had some other ways of monitoring staff movements in, I think there was key fobs or audio?

A. Yeah, so each staff member that comes on site has their own pin to a set of keys. A lot of our movements through the centre are via a fob and we can track those so we can see who's moved through which doors, so which units they've moved up to at what times. We also have intercoms within each young person's room and they pick up and record audio, so we can go back and listen to the audio as well.

Q. Thank you. And, you made a comment in your statement about how the complexity of children and their needs, their complex needs, have increased as you've seen a decrease in the number of detainees.

A. Yeah, so ACT has made a move, you know, it's several years ago now, back in 2008, to ensuring that custody is a place of last resort, and so, what we do see is young people who have committed the more serious ends of offences or have complex recidivism in their offending, and the complex nature of the young people we've also seen an increase in, so the level of undiagnosed disability, mental health concerns, is definitely something in my 20 years that I definitely think the young people are a lot more complex now in their trauma experience and their needs.

Q. Thank you. My final one was, I believe that the young people and maybe even their family members have also got right of review in your system?

A. Yeah, that's right. So, there are decisions that, you know, that young people and their family members can make complaints about anything that they've got concerns about and we will look into those complaints, but they also do have right of review over decisions that are made about them, such as if they're put on a safety and security segregation or, you know, even if they get a fine they can ask for that decision to be reviewed.

1
2 COMMISSIONER BROMFIELD: Thank you, that was all of my
3 questions. Thank you for your evidence.
4

5 PRESIDENT NEAVE: Q. Thank you very much, Ms Grace. I
6 have one quick question, and I ask it having regard to the
7 fact that you've said that the young people who are in
8 custody are now more complex and have more complex needs
9 than was perhaps the case in the past. Has there been an
10 improvement in terms of recidivism, I suppose is a crude
11 measure but one measure, following the move from Quamby to
12 Bimberi?

13 A. Recidivism, I think, is something that's really
14 difficult for us to measure. We have such a small
15 population that, you know, the way in which we counter it
16 jumps back and forth so much. We definitely have lower
17 numbers of young people in custody and that has been quite
18 consistent, but I wouldn't be able to say off the top of my
19 head.
20

21 Q. I think we heard here about a pattern of people coming
22 back again and again?

23 A. Yeah.
24

25 Q. And, have you got a cohort who come back again and
26 again?

27 A. Yeah, we do have a cohort that come back, and come
28 back to us, and they are some of our most complex young
29 people in the ACT, so yeah.
30

31 PRESIDENT NEAVE: Thank you. Thank you very, very much
32 for your evidence and for coming here to give it.

33 A. Thank you.
34

35 MS RHODES: Thank you, if Ms Grace could be excused for
36 our next witness.
37

38 PRESIDENT NEAVE: Thank you very much.
39

40 MS ELLYARD: Thank you, Commissioners, I'll now recall
41 Mr Pervan to continue his evidence. I understand that he's
42 waiting outside. I'll invite him to come back into the
43 witness box and his counsel to take their place again at
44 the Bar table.
45

46 Thank you, Commissioners, I believe we're ready to
47 resume and I'll ask those in the public gallery to take

1 their seats.

2

3 PRESIDENT NEAVE: We don't need to re-swear, Mr Pervan,
4 but of course he's conscious of his obligations.

5

6 <MICHAEL PERVAN, recalled: [10.22am]

7

8 MS ELLYARD: He understands that he's bound by the oath he
9 made yesterday, and I think it's also important to note,
10 Commissioners, that Mr Pervan's here today and continuing
11 with his evidence in the context of some health issues that
12 are being managed and, if at any time, Mr Pervan, you need
13 to step down for health reasons, please do let me know and
14 we can take any necessary break.

15 A. Thank you.

16

17 Q. Mr Pervan, you'll be aware of the fact that over the
18 20-year period which the Commission is considering there
19 have been a large number of reports or reviews that have
20 considered or touched on Ashley and its operations?

21 A. Yes.

22

23 Q. And indeed in the more recent past you've commissioned
24 some of them yourself, you touched yesterday on the fact
25 that you commissioned the report by Ms Harker; is that
26 right?

27 A. Yes.

28

29 Q. And thereafter the report by Noetic?

30 A. Yes.

31

32 Q. There's also a number of other reports in the more
33 recent past from the Custodial Inspector and the Children's
34 Commissioner which have touched on Ashley and relevant
35 matters?

36 A. Yes.

37

38 Q. Would you agree with me that the kinds of issues that
39 were raised in Ms Harker's report are very similar to
40 issues that had been raised in reports earlier in the life
41 of Ashley?

42 A. Yes, I would agree.

43

44 Q. If we go, for example, to Ms Harker's report, she
45 found in 2015 that there had been a cohort of staff who had
46 been there a long time which had impacted workplace
47 culture; do you agree with that?

1 A. I do.

2

3 Q. She found that, although there was a willingness on
4 behalf of operational leadership to working well with young
5 people, leadership's influence appear to have dissipated
6 over time so that there was still a culture leaning towards
7 punishment rather than rehabilitation as at 2015?

8 A. Yes.

9

10 Q. And she found that there was a lack of governance and
11 management presence and direction in a number of critical
12 areas at the centre?

13 A. Yes.

14

15 Q. Particularly in relation to staffing, she found that
16 at that time in 2015 there was an over-reliance on casual
17 staff and a lack of what was regarded as an appropriate
18 ratio of staff to young people?

19 A. Yes, I recall that.

20

21 Q. And she found at that time in 2015 the number of
22 WorkCover and sick leave applications raised concerns about
23 whether staff were able to care appropriately for young
24 people whilst keeping themselves healthy?

25 A. Yes.

26

27 Q. And that there were some poor conditions for young
28 people with one bright light perhaps being, even then, the
29 school: yes?

30 A. Yes.

31

32 Q. As I understand it, that report concerned you?

33 A. M'mm.

34

35 Q. It was a report which came to your attention in June
36 2015?

37 A. Yes.

38

39 Q. So when you'd been in the role as either Acting
40 Secretary or Secretary for perhaps a year?

41 A. More or less, yes.

42

43 Q. As I understand it from your evidence yesterday, in
44 the light of that report from Ms Harker you commissioned
45 the Noetic review?

46 A. In terms of the design of the building, yes - of
47 buildings and the centre itself, that was where the Noetic

1 work started and it quickly grew into a model of care, but
2 separate work was undertaken around the other
3 recommendations of Ms Harker's report.
4

5 Q. And so, thinking about 2015, her report raised a
6 number of serious issues, what was that separate work that
7 you're saying was done to deal with such matters as
8 workplace culture and staffing?

9 A. The division that was subsequently managed by Mandy
10 Clarke, at that stage it was Tony Kemp who was the Deputy
11 Secretary, took on board all of the recommendations - in
12 fact I have a report related to the work plan that was
13 undertaken in that division following the Harker and Mark
14 Morrissey's major report which implemented within the
15 resources we had all of the recommendations.
16

17 And, if I can reflect back at this point, I think
18 reading this over the last few days it's occurred to me
19 that we've always embraced all of the recommendations of
20 the independent reviewers and of the Commissioners for
21 Children and what follows is a traditional, if you like,
22 public service response where we see an action that's
23 recommended, we implement the action, we mark it completed
24 and we move on and we report back to government that all
25 the recommendations have been implemented.
26

27 In retrospect, those cultural issues are far harder to
28 change, and reflecting on Mandy and Pam Honan's evidence, I
29 think myself personally didn't understand the depth and
30 strength of, if not the culture of the institution, the
31 culture around a group of individuals and their resistance
32 to change.
33

34 So, the assumption made in implementing the
35 recommendations was that substantial training and resources
36 being put in, education, performance management,
37 supervision and so on could actually result in a cultural
38 change, and all those things were implemented but, as we've
39 heard from subsequent reports, the culture of that group of
40 people didn't shift where we wanted it to go to.
41

42 Q. And that culture of that group of people, recognising
43 that it wasn't ever the whole of the workforce, but that
44 culture has dominated over what it appears have been
45 successive attempts at reform over the years, both since
46 you were the Secretary and perhaps even before then?

47 A. Yes.

1
2 Q. And so, that means that what we saw then in the report
3 that was done in 2020, the AYDC Discovery Report, which I
4 think you've said in your statement you weren't aware of at
5 the time but you've looked at since we asked you to do it,
6 we see really the very same themes, don't we, that
7 Ms Harker had brought to your attention five years
8 previously in terms of a lack of understanding and
9 implementation of a therapeutic framework?

10 A. Yeah.

11
12 Q. And in effect what Ms Harker observed was the failure,
13 in terms of actually being embedded in a real way, of the
14 therapeutic framework that your staff and you had sought to
15 implement after the Harker and Noetic work was done?

16 A. Yes. And, to credit Pam Honan and her team, the
17 approach they took with developing the current practice
18 framework, which was built from that ACF 2020 report, was
19 done in an entirely different way. So, the practice
20 framework as she was describing was actually driven through
21 a co-design process with the young people at Ashley and the
22 staff.

23
24 Our response prior to that was to bring in an expert,
25 tell us what to do, and to try and implement it by
26 direction, and as a consequence people who were resistant
27 to change found it quite easy to let it wash over them and
28 wait for the next turnover of Secretary or Deputy
29 Secretary, and I'm aware that amongst a few of the staff
30 there, there has been that attitude of, if we just bunker
31 down and wait, there will be a new Director, there will be
32 a new Centre Manager, there will be a new Secretary. I've
33 seen emails to that effect, that they rely on the turnover
34 in management to outlast any attempts at reform. The
35 difference in the practice framework is that the staff who
36 are there now own it because they helped to develop it, as
37 did the young people.

38
39 Q. At the beginning of your statement in response to
40 Request for Statement 104, you make the observation that
41 since your appointment as Acting Secretary the department
42 hasn't been successful in being allocated the additional
43 funds necessary to drive faster reforms of the service. We
44 heard about a particular example in Ms Clarke's evidence
45 yesterday of a budget decision that didn't work. But I
46 take it you're making a larger point about the extent to
47 which funds have been allocated to your department over the

1 last eight years --

2

3 MR GUNSON: I must object, Commissioners, to this line of
4 questioning that, unless my friend is very careful, is
5 moving into Cabinet-in-Confidence budgetary processes
6 which, with respect, are Cabinet-in-Confidence and the
7 allocation of budgets is not within the terms of reference
8 of this Commission.

9

10 PRESIDENT NEAVE: As I understand it, Ms Ellyard's
11 question was a slightly different one. Can I ask you to
12 clarify that question, I think that you were asking about
13 budgetary processes, I thought that your point was a
14 broader one.

15

16 MR GUNSON: And out of fairness to my learned friend I
17 have jumped up potentially a little bit early just to flag
18 the issue.

19

20 PRESIDENT NEAVE: Thank you.

21

22 MS ELLYARD: Let me make it plain that, to the extent that
23 this witness is aware of Cabinet-in-Confidence processes
24 I'm not inviting him to reveal them. I'm inviting him to
25 speak to what he has said in his statement which is a
26 reflection on his time as Secretary and the extent to
27 which, whatever the reasons for it, there hasn't been money
28 flow through to the extent that he thinks appropriate to
29 enable the reforms to be done more quickly. That's the
30 question I'm asking and, no doubt the witness can answer it
31 conscious of the matters that Mr Gunson has raised.

32

33 PRESIDENT NEAVE: Mr Gunson.

34

35 MR GUNSON: And I have no issues with the witness giving
36 evidence that as Secretary of the Department he felt that
37 he didn't receive from the budget as much as he would have
38 liked --

39

40 MS ELLYARD: With respect, Mr Gunson shouldn't tell the
41 witness what the answer should be.

42

43 MR GUNSON: No. With respect, I'm not telling the witness
44 what the answer should be, I am simply saying that, for a
45 Secretary of a department and that is any department to
46 make a comment on whether they were satisfied with the
47 amount of money that was received from the budgetary

1 processes to achieve what they wanted to achieve is a
2 perfectly legitimate question to be asked.

3

4 PRESIDENT NEAVE: Mr Gunson, you are no longer raising
5 concerns about the question Ms Ellyard is asking.

6

7 MR GUNSON: No.

8

9 PRESIDENT NEAVE: Thank you.

10

11 MS ELLYARD: Do you want me to re-ask the question,
12 Mr Pervan, or do you have the sense of it?

13 A. I've got the sense of it.

14

15 Q. Please.

16 A. And I'll borrow from the words of Kathy Baker from
17 yesterday, that the budget process in Tasmania is hotly
18 contested, agencies do put bids in for a range of
19 initiatives from Education, Health in particular, and of
20 course our own. The results of the deliberations of
21 government in allocating budget was that perhaps we weren't
22 able to win the funding we needed to meet our ambitions for
23 the service, but that's a reality of public administration,
24 we took the budget that we were granted and we did, as has
25 been demonstrated for me again, we did a pretty good job of
26 implementing all the recommendations within the funding we
27 had. Could we have done more? I think any senior
28 administrator would do more if they had the funds, but what
29 we tried to do was to cut the cloth, I believe the
30 expression is.

31

32 Q. Thank you, and you go on in the immediately following
33 paragraph at the beginning of your statement to say that
34 you don't recall a time when you've been involved as Acting
35 Secretary or Secretary when the level of staff with
36 necessary skills was ever sufficient to support the
37 transformation of the service that was required; is that
38 right?

39 A. Yes. So, in saying that, what I was pointing to was a
40 dynamic, it was two things. In an ideal world you would
41 have sufficient staffing so that you could maintain full
42 safe staffing while you had other staff away from the
43 service undertaking training and development and bringing
44 them up to speed with an emerging area which is therapeutic
45 care.

46

47 The dynamic at Ashley is that, because of staff

1 turnover, we've never actually ever been able to get a full
2 permanent workforce up there so that there has been times,
3 as we all know, when we've been unable to maintain full
4 safe staffing without using overtime and double shifts and
5 things like that.
6

7 Q. We've heard evidence that at the moment the problem's
8 particularly acute at certain times with particularly acute
9 consequences for young people.

10 A. Yes.

11
12 Q. But it's an issue that was certainly being flagged
13 with you as early as Ms Harker's review and it's been a
14 constant over the period of time you've been involved as
15 Secretary?

16 A. Yes, we've had times where we've been very fortunate
17 with recruiting and we've come very close to full staff,
18 but then through a variety of reasons we've then lost
19 significant numbers through retirement, illness and so on,
20 and we've had to go back and keep recruiting. It's a very,
21 very hard service to recruit to, not many people want to
22 work in the area and certainly having it based where it is
23 doesn't help with recruitment.
24

25 Q. Indeed, and one of the recommendations of the Noetic
26 Report which Mr McGinness has given evidence about earlier
27 in these hearings but which you received in your capacity
28 as Secretary, was that the service should be located other
29 than where it is?

30 A. Yes.

31
32 Q. Because of issues associated with workforce as well as
33 issues associated with young people having access to family
34 and support and professional support?

35 A. Yes.

36
37 Q. When the Noetic Report was commissioned with its clear
38 recommendation coming to you and to the government that
39 there should be a closure of Ashley and the replacement of
40 Ashley with two new centres, did you yourself form a
41 personal view about whether the proposal offered by Noetic
42 should be accepted by the government?

43 A. I recommended it to government, so yes, I did. Can
44 I - sorry, counsel, if I could just note: that was the
45 preferred option in the Noetic Report. Noetic also gave us
46 an option keeping the current site and significantly
47 investing in it and redeveloping it and training the staff.

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Q. It did.

A. So, it wasn't a single reception.

Q. No, but just to be clear, they had a preferred model which they commended to you and is that the model which you commended to government?

A. Yes.

Q. Was it, in your view, the best option going forward for detention facilities for young people in Tasmania? The best of those available?

A. Thank you. Within the report, that was the best recommendation. Even in 2016 I was unsure whether we needed one or two centres, but certainly having a new facility closer to either Launceston or Hobart was, I saw as a logical way of addressing the staffing challenges we had as well as some of the issues around the support services from Health and Education having to travel great distances to get to Deloraine when we need them sometimes in an emergency.

Q. There was quite a long period of deliberation, was there not, between when the Noetic Report was received and when a decision was made and publicly communicated about which option would be taken up? As I understand it, the report's dated October 2016 and it wasn't until June 2018 that there was an announcement made by government that they were going with not the preferred option but a secondary option of additional resourcing to Ashley where it was?

A. That's my recollection, yes.

Q. In that two-year period, aware as you obviously were of the issues that Ms Harker had raised and that the Noetic Report had raised, what steps were you able to be taking in the interim, as it were, to be addressing the issues that Ms Harker and the Noetic Report had identified?

A. So, the report was with government from 2016. In the meantime we were continuing to pursue Heather Harker's recommendations, and those that were made and additional recommendations or requests that came from the Commissioner for Children. As with the current Commissioner, I met with Mr Morrissey on a monthly basis, and those discussions were predominated by issues at Ashley?

Q. As I understand it one of the pieces of work that emerged was the Ashley+ approach which then became the

1 Ashley Model of Care approach, and I think as we've already
2 touched on, the work that was done on each of those
3 approaches didn't ultimately take root and solve the issues
4 of culture and practice that had been identified?

5 A. I would agree with that, and I think out of respect to
6 the people involved, that was our best efforts, our best
7 endeavours to try and implement the kind of changes that we
8 saw from those reports and that we knew we needed to do
9 within the resources we had.

10
11 Q. And certainly, given the descriptions of the
12 experiences of some detainees that the Commission has heard
13 either through their own direct evidence or through the
14 observations of witnesses like Alysha and Ms Gardiner when
15 they gave their evidence, it would appear that, at least to
16 some extent, concerning practices in relation to young
17 people persisted despite the good efforts of those who were
18 trying to put in place new frameworks; do you accept that?

19 A. Yes.

20
21 Q. And so, Ashley was defeating, as it were, or at least
22 the culture at Ashley was defeating the attempts that were
23 being made to implement and embed new practices?

24 A. Yes, and without wanting to repeat myself, I think
25 that was not so much the culture at Ashley, but it was the
26 dominance of a group of people at Ashley who were able to
27 outlast or just dominate all efforts at change.

28
29 And if I could, having listened to the lived
30 experience witnesses and knowing the years that they were
31 in Ashley, what I have noticed is that the people whose
32 time at Ashley is oldest have a general and very
33 understandable disdain for the youth workers and their
34 experiences there. As we get into more recent times you'll
35 get statements like, "Not all the youth workers were bad,
36 some of the youth workers were great", and that's not
37 enough, I'm not saying that we're on our road to where we
38 want to be; I've just noticed that there is change starting
39 to creep through over time.

40
41 And, it's a very small thing, a very, very small
42 thing, but one of my personal strong memories of an
43 indication of change is when - and I'm sorry, I can't
44 remember whether it was 2016 or 2015 - but after discussion
45 with the young people a proposal was put to me through the
46 staff that the young people at Ashley should have a school
47 uniform and they should design it. They shouldn't have to

1 go to school in their Ashley tracksuit, they should have
2 the same right as any other school child and be allowed to
3 have a uniform. And just that little tiny gesture was a
4 sign for me that there were people in Ashley who were
5 trying to make it better, who were trying to make it more
6 something approaching a normal life for young people.

7
8 Q. Yesterday you agreed with - well, I think you accepted
9 that it was your own observation too, the observation that
10 Ms Clarke and Ms Honan had made in their evidence about the
11 disconnect between Ashley Management and Operations from
12 the broader department which they observed in October 2019
13 or thereabouts when each of them started.

14 A. Yes.

15
16 Q. You'd been the Secretary for the best part of five
17 years by then, of course recognising a period of time when
18 you weren't the Secretary because Ashley was in a different
19 department from yours.

20
21 Q. Doesn't that reflect on the management above Ashley in
22 the hierarchy up to and including you if, if up to 2019 the
23 Ashley Management had been permitted to isolate themselves
24 and not participate properly as part of the department?

25 A. There is a reflection there, I'll own that; I was also
26 running the Tasmanian Health System, so it wasn't as if I
27 wasn't aware of the issues at Ashley, and I very much
28 depended on a succession of Deputy Secretaries to be
29 informing me, as I was those conversations with the
30 Commissioner for Children and Young People as to what was
31 happening at Ashley and what I needed to do to remedy it.
32 And, as I've said before in respect to out-of-home care,
33 part of that response of responding to the information I
34 had access to was to get Heather Harker in and then the
35 subsequent reports from Noetic and the ACF.

36
37 It was very difficult to find out exactly what the
38 situation was at Ashley other than noting that it was a
39 facility that was isolated and had isolated itself over a
40 considerable period of time. As with the Deputy Secretary
41 and Director level, there was a succession of centre
42 managers, and getting to grips with not only what was the
43 problem but what we could actually do about it was
44 incredibly challenging.

45
46 Q. And so the practical effect of that, and I've heard
47 what you've said and I want to come back to the

1 point you've made about also running Health at the same
2 time, was that it appears that over a series of years the
3 self-isolation of Ashley from the scrutiny that might be
4 best practice in terms of an open line of communication up
5 through the Director of Custodial Justice and up through
6 the Deputy Secretary to you, that was able to continue so
7 that it was still in place in October 2019?

8 A. Yes.

9
10 Q. And so, I'm interested to understand, it's clear from
11 your evidence that you commend very highly to the
12 Commission the work done by Ms Honan and Ms Clarke in a
13 their respective roles?

14 A. Yes.

15
16 Q. And it's clear that you would draw quite a bright
17 line from perhaps early 2020 onwards in terms of steps that
18 had been taken to bring about what you would regard as
19 genuine cultural change now; is that right?

20 A. We're on the way. It'll take a decade before what
21 you've got there is at least a benchmark facility and
22 service, whether it's at Ashley or it's, you know, at the
23 two new facilities. Changing those cultures are not just
24 about changing people's attitudes; in many respects they're
25 about changing the people themselves.

26
27 Q. If this Commission had been happening four years ago
28 when the Ashley+ Model was being rolled out might you not,
29 Mr Pervan, with respect, have been saying exactly the same
30 thing, "We're on the way, we've got this new framework"?

31
32 We now know with the benefit of hindsight that, for
33 the reasons you've explained, the solution hadn't been
34 found; what is it that gives you confidence that in another
35 five years we wouldn't be reflecting in the same way on
36 what's happening now that we can reflect on in previous
37 models?

38 A. I think the difference between four years ago and now
39 is - well, are two things: four years ago it would have
40 been faith in the staff reporting to me and hope, because I
41 would have received a report just like this one that would
42 have had all of the actions that have taken place in
43 response to the various recommendations.

44
45 I'm still hopeful, because of the leadership that
46 we've recruited, and particularly the newest recruit that
47 we have and his experience and his credentials and

1 understanding in providing trauma-informed care. The
2 difference four years ago to now is, I have some evidence
3 of change in front of me.
4

5 Q. Pardon me a moment. So, clearly what you've
6 identified is the significance of leadership, leadership in
7 the form of the current holders of positions like Ms Honan
8 and the recently former Deputy Secretary, Ms Clarke?

9 A. Yes.

10
11 Q. You've made it clear in your evidence that the way in
12 which you exercise your responsibilities as a Secretary is
13 in a delegated way, and you're not yourself an expert in
14 Custodial Youth Justice and you rely on others to provide
15 you with expert advice as and when you need it.

16 A. Yes.

17
18 Q. And I'm conscious of the fact that there's about to be
19 administrative changes and you'll cease to be the person
20 who's responsible for Ashley, but what to your mind is the
21 role of the Secretary in leading the kind of change we're
22 talking about? You're not the expert, but you've got to
23 make sure that the change happens; what is it that you have
24 sought to do or that you think needs to be done by the Head
25 of Agency to ensure that the changes that are in place now
26 are changes that will endure?

27 A. Principally, it's providing the authorising
28 environment to make sure that I get whatever resources I
29 can get to back it up; that I enable the people in those
30 leadership positions to do that and, where I do go
31 recruiting, I go recruiting for someone who's got the
32 skills, the capability, the experience and credentials to
33 deliver that, and the new Executive Director of Youth
34 Justice reform fits that bill and I am - one of the things,
35 one of the few things I'm happy about in saying farewell to
36 this service in a few weeks time is that Chris Simcock has
37 started and I think he will be excellent in driving the
38 sort of change we need at those services.
39

40 Q. One of the things that you said when I asked you about
41 the extent to which it reflected on you that Ashley
42 management had been able to distance itself in the way that
43 it had was that you were at that time also running the
44 Health Service, and you were reflecting on the fact that in
45 those years Ashley was part of Human Services which was
46 part of a large Department of Health and Human Services.

47 A. Yes.

1
2 Q. I was going to come back to this later but I'll ask
3 you now. I take it you were saying there, you couldn't
4 give all of your attention to Ashley, you had to also give
5 attention to other, and frankly larger, parts of your
6 portfolio, namely the Health Department; is that fair?

7 A. Yes.

8
9 Q. The proposal for the future is that Ashley is going to
10 be part of a department that involves what's currently the
11 Education Department as well as parts of what's currently
12 the Department of Communities, and the practical effect of
13 that will be that Ashley and the Child Safety Service will
14 be part of a portfolio for a Secretary who's also managing
15 the whole of the Education system.

16
17 And I'm interested to invite you to comment on the
18 issues that that raises, something as complex and difficult
19 as Ashley being part of a very broad suite of
20 responsibilities for a Secretary where Ashley is smaller in
21 size, much smaller in number of children, but very
22 important.

23 A. I can't foreshadow what the Secretary of Education,
24 Children and Young People will do in terms of the structure
25 he might roll out. What I know he's got the benefit of in
26 terms of eyes on the services and the care that children
27 are receiving, is the Office of Safeguarding, and I'm sure
28 that will have an expanded role when the current
29 Communities Tasmania Services move across.

30
31 Since those days, those early days of 14/15, the
32 resources and the role of the Commissioner for Children and
33 Young People has been expanded and I think that that level
34 of independent oversight is going to be critical to how the
35 Secretary who's taking on the service will be able to keep
36 an eye on those issues of quality of care and the
37 individual concerns that young people moving through the
38 system have got.

39
40 Q. So, I don't want to put you on-the-spot, you're still
41 a senior member of the State Service and you're going to
42 continue to be with different responsibilities, but we've
43 had some evidence and reflections offered to us through
44 this week and through other evidence concerned that Ashley
45 will be lost in a larger department and that it won't -
46 it's the hardest point, yes, most difficult part perhaps of
47 any portfolio and that it just won't get the attention that

1 it's going to continue to need, Ashley or its replacements,
2 in such a large departmental structure. Is there a comment
3 you would make on the risks of that? I'm not asking you to
4 comment on particular people and whether they'll do their
5 job.

6 A. Thank you. Look, I think it's an identifiable risk
7 and I think that the new agency is focusing on, not just
8 that but in the other services that are moving across and
9 how they can be assured that those risks are being
10 mitigated.

11
12 Q. Thank you. Can I turn to a different topic before we
13 take the morning break. One thing that isn't delegated in
14 your department and that you remain responsible for is the
15 commencement of Employment Direction 5 and Employment
16 Direction 4 processes, that is, investigations into whether
17 there is a breach of the Code of Conduct and associated to
18 that whether or not a worker should be stood down?

19 A. Yes.

20
21 Q. And it's clear that, although investigations are done
22 by others and advice is provided to you, ultimately it's
23 your decision to make about whether to commence an
24 investigation?

25 A. Yes.

26
27 Q. And it's your decision ultimately to determine, after
28 the investigation's done where it's been completed, what
29 action, if any, should be taken?

30 A. Yes.

31
32 Q. And similarly, it's your decision to decide whether or
33 not to suspend someone with pay?

34 A. Yes.

35
36 Q. And you also have the power to make a representation
37 in an appropriate case to the Head of the State Service
38 that someone should be suspended without pay?

39 A. Without.

40
41 Q. And we know that in the recent past there have been a
42 number of ED5 processes commenced which are ongoing; is
43 that right?

44 A. Yes.

45
46 Q. Associated with that there are a number of people who
47 have been suspended under ED4?

1 A. Yes.

2

3 Q. I'm obviously not going to ask you to comment on any
4 current investigations, but I wanted to ask you: you were
5 present yesterday for the evidence of Ms Clarke and
6 Ms Baker which touched on the way in which information is
7 gathered to help a Head of Agency decide whether they can
8 have a belief on reasonable grounds that a breach of the
9 Code of Conduct may have occurred?

10 A. Yes.

11

12 Q. It appeared from their evidence that, thinking
13 particularly about historical matters, there's sometimes
14 quite a bit of work that's gone into investigating before
15 matters have been put up to you for your consideration?

16 A. Yes.

17

18 Q. And that's been your experience, that you've heard
19 about things sometimes after they've been bubbling away for
20 a while?

21 A. Yes.

22

23 Q. And, in particular, thinking about three matters which
24 came up in 2020 in relation to people who we're calling
25 Lester, Ira and Stan --

26 A. Yes.

27

28 Q. -- it appears that there were processes that were
29 underway for a number of months prior to you ultimately
30 making the decision to stand each of those people down in
31 around November 2020?

32 A. Yes, 8 November.

33

34 Q. In the context of ED5 processes being commenced?

35 A. Yes.

36

37 Q. And you were present when I questioned Ms Baker and
38 Ms Clarke about when and how they themselves became aware
39 of information and allegations about each of those three
40 workers?

41 A. Yes.

42

43 Q. And I wanted to clarify with you when you became
44 aware. Thinking firstly about Lester, the evidence is that
45 an allegation that Lester may have engaged in an act of
46 child abuse in the past was brought to Ms Honan's attention
47 in early January 2020, and on the evidence she made it

1 known to Ms Baker, who says that she told you. Do you
2 recall when you became aware that an allegation had been
3 made against a current employee of an historical nature?

4 A. I can recall the conversation that an historical
5 allegation had been raised. I recall that I was advised it
6 was problematic in that it lacked sufficient particulars
7 for us to act on right at that point, and that we were
8 also - I was also told that, because of the nature of where
9 the information had come from, we had been told at that
10 stage that we couldn't use it because it was a redress
11 matter.

12
13 Q. So, I just want to understand that. I'm asking
14 about - and you've received lots of information over
15 the years - I'm asking about information that was derived
16 from a report from a current Ashley staff member of an
17 allegation that she, Alysha, had become aware of. So, as
18 at January were you told that it was a redress-related
19 matter?

20 A. My recollection was that it was one and the same. So,
21 the information had come forward out of redress; I don't
22 know how Alysha obtained the information, but in terms of
23 where the allegation originally emerged from, the advice I
24 had was that it was a redress matter.

25
26 Q. So, the advice you received was that it was a matter
27 that was known to the department already through a redress
28 claim?

29 A. Yes.

30
31 Q. I want to pushback on that: it certainly does seem on
32 the evidence, Mr Pervan, that over the course of the period
33 from January to November additional matters may well have
34 come to your attention revealing that, in relation to
35 Lester, matters were known through the Abuse in State Care
36 System.

37 A. Yes.

38
39 Q. But the evidence of Alysha and of Ms Baker is that the
40 information brought forward in January was derived from -
41 Alysha heard it from another worker and forwarded it on to
42 Ms Honan. I don't think the evidence is that it was
43 related to a redress matter at that early stage, but you
44 have a different recollection?

45 A. I have a different recollection. It may be that the
46 allegation is identical to one of the ones that came in
47 redress and that the worker who reported it to Alysha got

1 it from another source. Regardless, sorry, what I should
2 have said up-front was, it doesn't really matter to me on a
3 personal level what the source of the allegation is: if I
4 hear an allegation of sexual abuse or abuse of any sort
5 against a young person at Ashley, I'm going to ask for it
6 to be investigated or at least progressed as quickly as
7 possible. The fact that - sorry - the fact that it didn't,
8 as was indicated yesterday, was because there were problems
9 around that information, but I wouldn't have said, "I don't
10 want to hear it anymore", or, "Don't do anything about it",
11 I would have said, "Get back to me with what we can do
12 about it as quickly as possible".
13

14 Q. And it seems that they did ultimately get back to you
15 in November and when presented with the information you
16 formed the requisite view and you commenced an ED5 process
17 and you suspended Lester, but that does leave a period of
18 some 10 months where, on the evidence, Lester remained in
19 the workplace. Were you aware through the year of the fact
20 that this matter that was perhaps bubbling away being
21 investigated involved someone who was continuing to work at
22 Ashley?

23 A. The assurances I had at the time was that there were
24 measures in place to make sure that Lester wasn't having
25 unsupervised or direct one-on-one access to young people.
26 I'm also aware that we were doing everything we could, and
27 certainly Jacqui Allen and the people that came before her
28 were doing everything they could to get sufficient
29 information for us to progress a matter if we could get the
30 necessary information, and that the authorising
31 environment, to use that expression, to progress with that
32 ED5.
33

34 Q. It mustn't have sat very well with you, though --

35 A. No.
36

37 Q. -- the fact that he was remaining in the workplace
38 where there were these issues of potential very serious
39 conduct being investigated?

40 A. Yes - no, that's - no, it did not sit well with me at
41 all.
42

43 Q. I want to ask you the same question about Ira. As we
44 understand the evidence, in the case of Ira information was
45 received by you arising from a National Redress claim and
46 you yourself made a report to police in February 2020 --

47 A. Yes.

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Q. -- that allegations had been made. And, I take it, you did that because the information that had been brought to your attention did seem to you a proper matter for the police to be aware of?

A. Any allegation of child sexual abuse is something I want police to be notified of.

Q. Yes, and you thought that it was appropriate that that be done in a timely manner?

A. Yes.

Q. Which you did?

A. Yes.

Q. But again, Ira wasn't stood down until 9 November, and what steps, if any, did you take to satisfy yourself during that quite long period of time that children weren't going to be placed at risk from him?

A. I was meeting on a very regular basis with Mandy Clarke and with Kathy Baker, and they were - I don't want to say that they were assuring me, because they were, but they were also assuring themselves that measures were in place to make sure that children weren't at risk by any of these people who were under suspicion.

Q. And so, I take it then, you received assurances which you felt able to be comforted by, that although Ira was still in the workplace, he wasn't in the workplace in a way that would give him access to children?

A. Yes.

Q. In the context of Lester, you'd received a similar assurance as I understand it?

A. Yes.

Q. And there's been some evidence that, notwithstanding the role that he had not being a role that formally gave him access to children, there was at least one occasion after the issues with him were raised where he did have direct contact with children and was involved in a strip-search. Have you been made aware of that evidence?

A. I am aware of that search and that was the subject of a very vigorous discussion at the time where I was assured that, while he was present at the - sorry, while he did conduct that search, it was under the watch of another youth worker who was in the room with him. So, once again,

1 even though the search proceeded in accordance with
2 procedure, he was witnessed doing that and it was logged
3 that there were two people undertaking the search at the
4 time, which has now become the standard practice.

5
6 Q. Nevertheless though, that's evidence of him engaging
7 in direct child-related work contrary to what it appears
8 from yesterday's evidence was Ms Baker's understanding
9 about --

10 A. Sorry, counsel, it wasn't just an understanding, it
11 was a direction and it had come from Mandy Clarke and from
12 Pam. So, I'm not sure of the particular operational
13 necessity for --

14
15 Q. Lester --

16 A. Lester, thank you - to have participated on that
17 search, but I was told that there was no choice and that,
18 because it was necessary to admit the young person, they
19 addressed the risk by having someone attend the search with
20 him.

21
22 PRESIDENT NEAVE: Q. So, can I just clarify that? There
23 was a formal direction given by either Ms Clarke or
24 Ms Honan that he should not come into contact with children
25 in any way; have I got that right?

26 A. That's my understanding, President, yes.

27
28 Q. And do you know when that was done?

29 A. I'm sorry, I can't remember that exact date.

30
31 Q. Can you take that on notice?

32 A. We can take that on notice, of course.

33
34 MS ELLYARD: Q. Just to complete the trio, thinking
35 about the way in which matters relating to Stan were
36 raised, as I understand the evidence, allegations of
37 potential sexual misconduct by Stan were brought to the
38 department's attention around June or July through a
39 potential civil claim that was raised; is that right?

40 A. That's my understanding now, yes.

41
42 Q. And so, that was evidence of someone who was prepared
43 to assert, through civil proceedings, that he or she had
44 been sexually abused in the past by Stan?

45 A. Yes.

46
47 Q. And again, it appears that it wasn't until November

1 that you were presented with and took action to suspend and
2 commence an ED5 process in relation to Stan?

3 A. That's correct.

4
5 Q. And in all of these cases, as I understand it,
6 Mr Pervan, the practice has been not to present a matter to
7 a Head of Agency until there's a sense that there's
8 sufficient particulars of the alleged allegations so that
9 you can form a belief on reasonable grounds?

10 A. Yes, that's correct.

11
12 Q. In practice what that seems to be is that there's
13 sometimes quite a long period of investigation --

14 A. Yes.

15
16 Q. -- before you're given the opportunity to consider
17 whether you have formed the relevant view?

18 A. Yes.

19
20 Q. And so, it seems then in practice that, although an
21 ED5 process is meant to be the start of an investigation,
22 in practice where these historical matters have been
23 concerned at least, quite a lot of investigation has in
24 practice been done before the matters have been put to you?

25 A. Once again, it comes down to what we're going to call
26 an investigation. So, some of the redress statements are
27 very, very broad, may not even give time spans, or often
28 the names are incorrect, and so, a lot of work goes into
29 just verifying the basic facts.

30
31 I'm aware that the people that were involved were
32 working as quickly as they could, there were the attempts,
33 going back through the Redress Scheme to contact the
34 victims. There was a lot of work going on, it wasn't
35 something that anyone was taking less than incredibly
36 seriously, and so, as much as you could call it an
37 investigation, it really was just seeking to validate
38 sufficient facts for us to proceed.

39
40 And, if I may, just to give a comparison - and I know
41 Jacqui Allen did this far more eloquently than I can -
42 where we were with ED5s, and by way of example I'll pick on
43 someone inappropriately using a government vehicle for
44 private purposes. We would require the specific dates,
45 times - this is before the ED5 investigation starts. So,
46 "On or about 4 August you used government vehicle
47 registration No.X to undertake private interests in

1 travelling to Melbourne on the ferry, and that's a breach
2 of the Code of Conduct for the following reasons"; it was
3 as full particulars as we could.
4

5 In the case of these more contemporary ones, we have
6 only sought to validate, if you like, the redress claims,
7 so in some cases the ED5s can be referring to a time span
8 of up to years, and very, very broad allegations. So, in
9 terms of that requirement to have a belief, where child
10 sexual abuse is concerned we've lowered the standard on
11 what we require for me to have that belief to trigger an
12 ED5 substantially.
13

14 Q. But I take it, and you've dealt with this in detail in
15 your statement, that you would take the view that, because
16 of the need to sufficiently particularise matters, even
17 matters relating to child sexual abuse, there's an extent
18 to which the ED5 and ED4 process is not fit for purpose if
19 that purpose is protecting children from the risk of sexual
20 abuse?

21 A. I would absolutely agree, counsel; I don't think ED5 -
22 ED5 is actually meant, or any public service disciplinary
23 process - and I've got experience of this in a few
24 jurisdictions - are based on behavioural correction, that's
25 why they're called disciplinary processes, and it does go
26 to inappropriate use of government resources or, you know,
27 deliberate misleading information in a timesheet; it's
28 generally those sorts of issues. Where you get to that
29 nexus where you're talking about essentially horrendous
30 crimes, it's not fit for purpose.
31

32 Q. Now, Ms Baker gave some evidence yesterday that, if we
33 think about matters that might come forward now for current
34 employees, she would ordinarily be - there'd be a briefing
35 by People & Culture and then a briefing for you immediately
36 so that you would become aware, even before you're being
37 presented with ED5 documentation, that a matter has been
38 raised. Is that your experience?

39 A. Yes.
40

41 Q. So that would mean that, to the extent that there's
42 any matters that might be going through - I'm going to call
43 it a preliminary investigation, that's not its formal
44 title - but the process of investigation to see whether
45 there's material to put to you, you would already know
46 about the existence of those matters?

47 A. I can actually give you direct reference. I think

1 two, maybe three weeks ago, an allegation was forwarded to
2 us on a Saturday afternoon from the Commission and the ED5
3 was commenced and the individual ED4'ed and asked to leave
4 the workplace on Monday.

5
6 Q. Okay.

7 A. So, a little different to the first two efforts.

8
9 MS ELLYARD: Thank you, Mr Pervan. Is that a convenient
10 moment, Commissioners, to take the morning break?

11
12 PRESIDENT NEAVE: Yes, thank you.

13
14 **SHORT ADJOURNMENT**

15
16 MS ELLYARD: Thank you, Commissioners. Mr Pervan, I
17 understand you're okay to continue, but please do let me
18 know if you need a break.

19 A. Thank you.

20
21 Q. I want to ask you some questions now about the
22 materials which it has become clear were made available to
23 People & Culture and ultimately used in some of the ED5
24 processes that have occurred in the last two years, and
25 that's records derived from the State-based Abuse in State
26 Care Redress Scheme which had four rounds between, as I
27 understand it, 2008 and 2013.

28 A. Yes.

29
30 Q. As I understand it, different parts of the apparatus
31 of government took responsibility for each of the four
32 stages; is that right?

33 A. Yes.

34
35 Q. And the final stage, which was reported on, as I
36 understand it, in 2014, was administered or held under the
37 auspices of the Department of Health and Human Services?

38 A. Yes.

39
40 Q. And so you in your capacity then as the recently
41 appointed Acting Secretary of the department, were the
42 author or signed off on the public reporting of that final
43 phase of the Scheme?

44 A. Yes.

45
46 Q. We understand from looking that report and the records
47 that sat behind it that of course that Scheme went much

1 more broadly than Ashley, but there were a significant
2 number of claims that were made under the Scheme relating
3 to the former Ashley Boys' Home and/or Ashley Youth
4 Detention Centre?

5 A. Yes.

6
7 Q. And you would have been aware, at perhaps a high level
8 of generality, that that was the case; that claims had been
9 made alleging abuse at Ashley?

10 A. Yes.

11
12 Q. At the time you became aware of that, which I assume
13 was around about the time that the report was published
14 under your name, did you turn your mind to the question of
15 whether or not any of the alleged perpetrators might still
16 be working at Ashley?

17 A. I don't recall that I did do that. What I do recall
18 was asking, regardless of whether they were employees or
19 not, what happens with this information on the grounds that
20 it was pretty clear that we were talking about horrible
21 criminal offences, and I just asked the general question,
22 "What happens with these?", and I was referred to
23 particular advice and a general practice which was current
24 across government until late 2020 where matters raised in
25 redress were not to be used for investigation, prosecution,
26 and the assumption of course that would have been made by
27 people in the People & Culture or Human Resources area was
28 that, if we were told that they couldn't be used for ED5,
29 then those matters weren't open anymore, that they weren't
30 tracked across time. Of course, regardless now, in
31 retrospect, regardless of that advice that we couldn't
32 pursue those matters, we should have come up with some way
33 of keeping track of that information, I can see that.

34
35 Q. As I understand it, the advice that you received when
36 you asked, "Well, what can we do with this information?",
37 was nothing?

38 A. Effectively. May I --

39
40 Q. And you understood that to be the practice that was in
41 place as at 2014 when you made that enquiry?

42 A. It wasn't just the practice, it was indeed that, but
43 looking at the independent assessments from the then
44 Ombudsman, Mr Allston, I think it was Simon Allston, there
45 are quotes in his reports which are in our summary review
46 that we did, where he actually references that someone put
47 to him that he should make a recommendation that this

1 material should be used for disciplinary purposes and he
2 rejected that on the grounds that redress was about healing
3 and compensation and not about punishment or pursuit, and
4 there were several explicit quotes across his reports as to
5 why information garnered from redress should not be used.
6 So, it wasn't just the presence of policy and legal advice
7 from the Crown, it was also these other reflections that
8 kept on reiterating that very uncomfortable message that
9 none of us were happy with.

10
11 Q. And so as I understand it you came to understand that
12 sitting behind the policy and practice that was in place as
13 at 2014 was legal advice that had been obtained from the
14 Solicitor-General's Office?

15 A. To my several predecessors behind me, yes.

16
17 Q. And that's advice that we've seen and privilege over
18 which has been waived, and I'll just ask my instructor to
19 place a copy of that advice from May 2017 in front of you;
20 I take it, that's a document you've seen - 2007, I'm sorry?

21 A. Thank you, I'm familiar with the advice, yes.

22
23 Q. That's advice that was provided, as you've said, to
24 your predecessor. The context of the advice was a concern
25 in the mind of your predecessor that allegations had been
26 made through the Abuse in State Care Scheme against persons
27 who were, relevantly for our purposes, still employed by
28 the department in some capacity?

29 A. Yes.

30
31 Q. And that some of the allegations might involve
32 criminal conduct or other inappropriate conduct?

33 A. Yes.

34
35 Q. And in the light of that three particular questions
36 were posed to the Solicitor-General: one related to whether
37 there should be prosecution; one related into whether there
38 should be any disciplinary action, and the third question
39 that was posed to the Solicitor-General was, is some other
40 action required to ensure proper protection for children in
41 care either now or in the future.

42
43 So it appears as at 2007 your predecessor was alert to
44 the possibility that the material being derived through the
45 Abuse in Care Scheme was potentially relevant to whether
46 children who continued to be in the State's care were safe?

47 A. Yes.

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Q. And advice was sought about the way in which, if at all, the material derived from the Abuse in State Care Scheme could be used?

A. Yes.

Q. And without doing full justice to the detailed advice which was there, it appears that the advice at that time was, the only way to achieve a successful disciplinary or indeed criminal prosecution outcome would be to have sworn evidence from the complainants?

A. Correct, yes.

Q. And that, in the absence of evidence on oath and a willingness to participate, it would be highly unlikely that a disciplinary process or a criminal process would be successful?

A. Correct.

Q. It doesn't appear that the advice, this advice, gave any specific reference to the extent to which the material might be able to be used in some other way?

A. No, I agree, yes, but of the --

Q. That it might be used in some other way to inform the way in which the department sought to protect children from people who had been identified in the Abuse in Care materials?

A. I agree, yes.

Q. So it's clear, therefore, that the Solicitor-General's advice wasn't that nothing could ever be done with the information; the advice was, absent evidence in a more traditional sworn form from complainants, it's unlikely that successful action could be taken against any individual person?

A. Yes. May I just add? Because this is an issue which has weighed heavy on me for quite some time, and while I don't welcome this advice and I'm glad that policy has now progressed past that, any action by the employer is appealable. So, for instance, if I were to take action against a particular employee because significant allegations had been raised against them, to transfer them to a job at level elsewhere, that's still appealable.

And one of the things that concerns me is, I can think of no greater nightmare for a victim to come forward, be it

1 through a sworn statement or otherwise, and to report, for
2 us to take action immediately and transfer that person,
3 have them win at appeal and have the Industrial Commission
4 direct us to return that person to the presence of the
5 victim.
6

7 Q. Clearly, and I think this is a point you've made in
8 your statement and it's made in other evidence as well, the
9 reality is that disciplinary processes must of necessity
10 favour the interests of the employee who's subject to
11 potential disciplinary action?

12 A. Yes.
13

14 Q. And that can often, not inevitably, but can often mean
15 that the benefit of doubt has to flow to that person in a
16 way that might not seem completely trauma-informed for a
17 complainant who's coming forward with significant
18 allegations?

19 A. I absolutely agree, there's nothing trauma-informed
20 about the ED5 process.
21

22 Q. To be clear, it appears that the Solicitor-General did
23 leave open the possibility that those who come forward
24 under the Abuse in Care Redress Scheme, if they wished to
25 participate in the next phase and give sworn evidence, that
26 would be open?

27 A. Yes.
28

29 Q. And so, what that would mean is that, it's not just a
30 case of, well, we've dealt with them for redress and given
31 them some more money, there's nothing more we can do; the
32 Solicitor-General's advice left open the possibility of an
33 invitation to those who had participated in the Scheme to
34 be part of another process of a disciplinary or criminal
35 nature?

36 A. Yes.
37

38 Q. And, as I understand it from the evidence we've had
39 yesterday, part of the Scheme did involve, "Would you like
40 us to tell the police?"; is that your understanding?

41 A. That's my understanding.
42

43 Q. As I understand the evidence though, there wasn't a
44 corresponding process that formally asked people at the
45 time whether or not they would be willing to be part of any
46 disciplinary process?

47 A. That's correct.

- 1
2 Q. And so, what that means is that, as successive phases
3 of the Scheme went through, the Solicitor-General's advice
4 wouldn't have prevented contact being made with former
5 detainees at Ashley who'd come forward with a claim to see
6 if they would be willing to participate in disciplinary
7 proceedings?
8 A. And that's what we've been doing for the last, I can't
9 count, but it's certainly more than 10, of the matters that
10 we're pursuing at the moment --
11
12 Q. That's what you've done since 2020?
13 A. Yes.
14
15 Q. But I'm inviting you to agree with me that even under
16 the now superseded advice, if superseded is the right word,
17 there was nothing preventing those in responsibility at
18 various times as claims came forward under the scheme from
19 reaching out to those claimants to see if they would
20 participate?
21 A. I agree, and in hindsight I should have pushed for
22 that. At the time, as I said, there were a number of
23 signals of indications from people like the Ombudsman that
24 that's not what redress information is for.
25
26 Q. Well, it's not what redress information is for, but
27 there was nevertheless a rich source of potential
28 complainants who it appears, by reason of a practice,
29 weren't ever contacted?
30 A. I agree and we should have.
31
32 Q. And in the more recent past I think you've made the
33 point some of them have been, and that's an ongoing
34 process, but at around the time you were publishing the
35 report in 2014 it appears that, because of practices that
36 had come to exist, no-one invited you to and you didn't
37 yourself reflect on the possibility of reaching out to some
38 of those 172 claimants from Ashley Boys' Home to see if any
39 of them wanted to be part of a disciplinary process?
40 A. No, the assumption was that we could not.
41
42 Q. Do you see with hindsight that perhaps that assumption
43 which had come to exist perhaps more broadly wasn't in fact
44 completely grounded in the advice that had been given?
45 A. Yes, thank you, counsel, I agree with you, I should
46 have questioned that.
47

1 Q. And so, one of the consequences of that is, we can now
2 see with hindsight, there were in fact a number of claims
3 made through the various iterations of that scheme that
4 related to people who were still employed at Ashley?

5 A. Yes.

6

7 Q. And who continued to be employed at Ashley, for years
8 in some cases, after sums of money had been paid to people
9 who claimed they'd been sexually abused by those workers?

10 A. Yes.

11

12 Q. And one such person is a person who we're referring to
13 as Walter, and I wanted to invite you to turn in your most
14 recent substantive statement, Mr Pervan, to paragraph 111
15 and following where you're answering Questions 30 and 31.
16 Have you got that page?

17 A. Yes, I do.

18

19 COMMISSIONER BENJAMIN: What was that paragraph again?

20

21 MS ELLYARD: It's the answer to Question 30, Commissioner
22 Benjamin. The question's 30 and then the paragraph of the
23 answer is paragraph 111 and following.

24

25 Q. Just to orient us both, Mr Pervan, for the purposes of
26 answering questions in your statement you were invited to
27 review some documents which reveal in summary the following
28 chronology in relation to Walter.

29

30 It appears that there were at least four Abuse in Care
31 claims that were made and received a payment in relation to
32 alleged sexual abuse by Walter in his capacity as someone
33 who had worked at the boys' home or the detention centre,
34 and the payments were made to people alleging that they
35 were abused by Walter in 2008 and 2010; do you agree that's
36 what the records show?

37 A. Yes.

38

39 Q. Walter remained employed at Ashley until 2017: yes?

40 A. (Witness nods.)

41

42 Q. And it appears that there wasn't ever a joining up, as
43 it were, or a provision of the information about those
44 allegations that had been made in 2008 and 2010; there's no
45 evidence that that material was ever made available to
46 those who supervised Walter or who might have been involved
47 in any other disciplinary investigations relating to him?

- 1 A. We've been unable to identify any, I agree.
2
- 3 Q. Given what you've said was the practice that you came
4 to understand existed, it appears most likely that there
5 wasn't anything done with that information other than to
6 have paid out the person who alleged the abuse?
7 A. Yes.
8
- 9 Q. And so, the fact of Walter being accused by at least
10 four people of sexually abusing them remained utterly
11 unknown, it would appear, to those who managed him at
12 Ashley or to anyone in the hierarchy above him at Ashley?
13 A. Yes.
14
- 15 Q. At the same time that that was occurring, and during
16 Walter's employment at Ashley he was the subject of
17 multiple allegations of sexual and/or physical abuse of
18 detainees which were investigated through a number of
19 different ED5 processes?
20 A. Yes.
21
- 22 Q. In fact, on one occasion I think he was criminally
23 charged though acquitted of an allegation that he'd
24 physically assaulted a detainee; are you aware of that?
25 A. Yes, I'm aware of it.
26
- 27 Q. One of the allegations against Walter which was
28 investigated related to the experiences of a young woman
29 who we're calling Erin, relating to conduct by Walter which
30 came to the attention of the Ombudsman?
31 A. Yes.
32
- 33 Q. You're aware of that?
34 A. Aware of that one, yes.
35
- 36 Q. What appears to have occurred in relation to Walter is
37 that on each of the - and Walter was stood down, as we
38 understand the records, at least six times during his
39 employment at Ashley because of concerns that were raised
40 about him which led to investigations: yes?
41 A. Yes.
42
- 43 Q. But on each occasion he was reinstated after the
44 investigations?
45 A. Yes.
46
- 47 Q. And it appears that, certainly as each of those

1 investigations into concerns about his alleged sexually or
2 physically inappropriate conduct occurred, no-one knew, and
3 no-one could bring into the analysis, the fact that there
4 were multiple historical claims of abuse alleged against
5 him which had been the subject of payments?
6 A. Yes.
7
8 Q. And interspersed with this were a number of sick leave
9 or WorkCover claims that were made by Walter?
10 A. M'hmm.
11
12 Q. Which appear, to at least some extent, to be lined up
13 with the times on which he was the subject of allegations
14 of misconduct: yes?
15 A. Yes.
16
17 Q. And the ultimate aftermath of all of that is that his
18 employment ultimately came to an end by agreement between
19 him and the department?
20 A. Yes, that's my understanding.
21
22 Q. Pursuant to an arrangement which saw him receiving a
23 lump sum arising from claims that he had made?
24 A. Yes.
25
26 Q. And there's no reference anywhere in that
27 documentation to the fact of the multiple allegations that
28 had been made against him?
29 A. Correct.
30
31 Q. Or indeed to the claims that had been paid out in
32 relation to alleged abuse by him?
33 A. That's correct.
34
35 PRESIDENT NEAVE: I'm sorry, this is my memory failure.
36 The six times on which he was stood down were for
37 complaints made subsequently to the Abuse in State Care
38 claims. So, we had the Abuse in State Care claims and then
39 an additional six complaints; have I got that right?
40
41 MS ELLYARD: That's my understanding, President, that the
42 claims having been paid out under the Abuse in Care scheme
43 in 2008 and 2010; between 2010 and 2017 the stand downs, as
44 I understand it, occurred or at least most of them did.
45
46 PRESIDENT NEAVE: Thank you.
47

1 MS ELLYARD: Q. Is that your understanding, Mr Pervan?

2 A. Yes.

3

4 Q. And so, you've answered some questions about this and
5 I wanted to touch on a couple of matters. Firstly, as I
6 understand it, and consistent with your earlier evidence,
7 there wasn't throughout this period any practice that would
8 have sought to make any use of those historical abuse
9 claims in assessing the current behaviour of a worker?

10 A. I've been unable to find any, no.

11

12 Q. And so, it appears that this rich potential source of
13 information about Walter, a person who was regularly coming
14 to the attention of management with serious allegations
15 against him, was never brought into the analysis of whether
16 he was someone who was suitable and appropriate to remain
17 in his job?

18 A. I agree.

19

20 Q. And he ultimately left on his own terms?

21 A. Yes.

22

23 Q. In the context of a number of very serious allegations
24 about him?

25 A. Yes.

26

27 Q. And in the context of, as the Commission now knows,
28 additional allegations being made about him by other
29 detainees who have come forward in the recent past?

30 A. Yes.

31

32 Q. Now, of course, I can't ask you to opine on whether
33 any one of those particular allegations are true or not,
34 but would you accept that stepping back and not attributing
35 responsibility to any person, that's a process failure, is
36 it not, the way in which information about Walter was
37 received and not used?

38 A. It is a system failure, yes.

39

40 Q. And it may well have meant that an opportunity was
41 lost to protect children entering Ashley in that period
42 from 2010 onwards from the risk that he may have posed to
43 them?

44 A. Yes, and to continue the discussion that has been
45 underway in front of the Commission for the last few days,
46 I have been present for discussions with the Head of the
47 State Service and other Heads of Agency triggered by

1 recommendations of the Integrity Commission around the need
2 to collect information around allegations; so, not
3 completed ED5 processes, but just allegations, and there's
4 been very robust discussion around the legality of keeping
5 such information when it doesn't progress further than the
6 stage of an allegation and, you know, what was the point
7 and purpose of doing so.

8
9 But, having listened to the evidence given over the
10 last week, I think that an exception, even if legislative
11 change is needed, an exception for matters involving the
12 safety of children needs to apply, such that that sort of
13 information can be kept, be it in a secure repository kept
14 by police or another body like that. But I agree that with
15 this case and some others there was a lost opportunity in
16 tracking those allegations across time. Whether they
17 manifested in disciplinary or criminal action or not, they
18 should have been watched.

19
20 Q. Thinking of course about the fact that ED5 processes
21 give the benefit of the doubt to employees, consistent with
22 an employer's obligations under industrial law, an
23 allegation being viewed in isolation without bringing into
24 account patterns of behaviour that have been alleged in the
25 past is an investigation that may well mean that there's
26 not a proper weight given to the particular allegation
27 being considered?

28 A. Absolutely.

29
30 Q. And so, there's a particular allegation that was made
31 in relation to Walter in 2016 of an allegation of sexually
32 inappropriate conduct by him and the investigator who
33 conducted that investigation and ultimately found, as I
34 understand it, in Walter's favour didn't know at all the
35 long history of similar allegations that had been made?

36 A. Yes.

37
38 Q. Which may have assisted that investigator in weighing
39 the material that they were able to find?

40 A. I agree, and if I could make a small request? In
41 looking to reform those sorts of processes, part of any
42 change has to be around the current restrictions imposed on
43 us from the Personal Information Protection Act, because it
44 may be - and I haven't sought opinion on this obviously -
45 but it may be that one of the reasons why that information
46 about events other than the matter under investigation
47 isn't provided to investigators is because there's a

1 general understanding that it requires the accused's
2 consent to pass that on to the investigator.

3
4 Q. I see. So that, even though it's material held by the
5 employer about previous matters relating to that
6 employee --

7 A. If it's not related to that specific matter under
8 investigation, then it's not ours to hand out to people,
9 except with the person's consent. And that's come up in
10 relation to reporting back to complainants about the
11 results of ED5, that we've been told that, without the
12 written consent of the person who's the subject of the ED5,
13 we can't provide any information whatsoever, and I've been
14 advised that that's entirely because of the PIP Act.

15
16 Q. So, I can understand there being potential limitations
17 about information confidential to an employee being
18 disclosed to an alleged complainant, but are you suggesting
19 that you've received advice or have an understanding,
20 Mr Pervan, that past complaints about an employee couldn't
21 be used in a subsequent investigation into that employee
22 without the employee's consent?

23 A. Yeah, with respect to passing them to an investigator.

24
25 Q. But isn't the investigator carrying out work on your
26 behalf?

27 A. On my behalf with respect to a specific allegation.
28 So, it's a flaw in the current system.

29
30 Q. And is that because the investigator doesn't work
31 directly for you and the Department of Communities?

32 A. Yes.

33
34 Q. Is it a problem that wouldn't exist if investigators
35 were State Servants?

36 A. If they were State Servants, but I also think we would
37 need to change the way that ED5 is written because if you
38 read it, and it might be a narrow reading, it appears that
39 the focus is on allegations and those particulars, so if
40 we're talking about bringing in other matters, the only way
41 you could bring them in would be to add them as separate
42 allegations, and have the whole lot investigated.

43
44 Q. To allege a course of conduct, as it were?

45 A. Yes.

46
47 Q. "It's alleged that on various occasions over this

1 period"?

2 A. Yes.

3

4 Q. And one might imagine that there might be individual
5 matters that come forward that in and of themselves aren't
6 sufficient to trigger a belief on reasonable grounds, but
7 once you've got four or five allegations, for example, that
8 might have some relevant similarities, the fact of there
9 being that many might get you to that point of thinking,
10 well, now I'm going to investigate?

11 A. Yes.

12

13 Q. But that will depend on having a system that --

14 A. Tracked.

15

16 Q. -- that tracked claims or allegations and kept them
17 effectively on an employee's file?

18 A. Yes.

19

20 Q. And does that not happen?

21 A. Generally, no, because the allegations - sorry: if an
22 allegation is made to us directly, then that information
23 would be on that employee's file. If they're in redress
24 applications, until recently, we wouldn't have been
25 receiving them for that purpose, they would have been
26 coming to us only to verify particular facts in order for
27 redress to process them. Similarly, civil claims, we
28 wouldn't keep that information on personal files. It is an
29 area that clearly is one right for reform and improvement.

30

31 Q. Yes, because - and again, continuing with Walter -
32 leaving aside the fact of there being information held on
33 redress files that wasn't available for the reasons you've
34 described, he was the subject over the course of his
35 employment of multiple ED5 processes and allegations, but
36 is it your evidence that even now, say he still worked for
37 you and a new claim came up, the investigator tasked to
38 investigate that wouldn't be told about the previous ones?

39 A. They would be tasked to investigate the specific
40 allegation, yes --

41

42 Q. So they wouldn't be told, this is a person who has had
43 multiple other matters raised against them?

44 A. Unless we wanted to put all of those allegations to
45 Walter and have him respond to all of them; there is a
46 procedural fairness issue in that and, once again, we're
47 back to ED5 favouring the employee so --

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Q. Because I could well imagine that, in thinking about your role as a Head of Agency, whether or not you formed a belief on reasonable grounds about a particular incident may well be informed by your awareness of the extent to which corresponding allegations had been made in the past?

A. Yes.

Q. But I think you're saying that the only way you would be permitted to have regard to them is if they're formally subject of the investigation. You couldn't use other matters to help you form a belief about a new matter; you'd have to --

A. So when the briefing comes up recommending me to consider an ED5, that would be the point where those historical issues should be raised. In the last few months, or last few years, I can't remember an occasion when they did and, once again, that information would need to flow through the investigation. So, if I thought that that information gave me a reasonable belief to commence an ED5, it would not be sustainable for me to have considered that information and for the investigator to then only investigate a narrow part of that, being the most current allegation.

Q. And this raises a question, and perhaps this is about ED5 as well, because as I understand it at the moment the way ED5 works is that, what can be alleged is specific breaches of the Code of Conduct.

A. (Witness nods.)

Q. One might imagine, and I want to get your comment on this: if you hear that a current employee has been the subject of, let's say, five or six allegations of a similar kind which, for whatever reason - time, availability of witnesses, whatever, haven't progressed but they're strikingly similar, made by people who wouldn't know each other tending to suggest that there's no collusion and so forth; at the moment it sounds like the only way you could do anything about removing that person from the workplace would be to investigate the truth of all of those allegations; is that right? You couldn't say, "Look, there's so many allegations, I'm just concerned, I'm losing confidence in you, I don't want you to work for me"?

A. So, I've just written myself a note to remind myself, I'm not a lawyer, and we are really getting --

1 Q. Of course, I'm asking you about process.

2 A. There's about 30 of them in the room so they probably
3 know more about this than I do. You are asking about
4 process, but it's a process bound by law.

5

6 Q. And I want to understand how it works in practice. My
7 understanding is, because one might take the view, using
8 Walter as an example: surely a point ought to have come,
9 one might say, where the sheer number of allegations made
10 against him of a similar size and shape over many years
11 brought it to the point where you might have wished to say,
12 "I don't want you working with children and I'm going to
13 stop you working with children". It sounds like in
14 practice, though, the only way you could achieve him not
15 working with children is to investigate and have specific
16 findings made about all of those different claims.

17 A. I agree with you, absolutely, and I would have loved
18 to have had access to that kind of process, and I don't
19 have it with me, but I can't recall whether it's in the
20 principles to the State Service Act or in the Code of
21 Conduct itself, where all decisions have to be procedurally
22 fair and demonstrably so.

23

24 So, if I was to take that action against Walter, or
25 anyone, I would have to be able to demonstrate that I
26 granted that person procedural fairness, so I'm making this
27 decision because of your history and you have a right of
28 response to tell me why I should or shouldn't make that
29 decision.

30

31 Q. And this is where we come to the question of a
32 disciplinary and employment related process really not
33 being the right way to deal with the risk, that one might
34 take the view that the nature and number of allegations
35 made against Walter invites a conclusion that you couldn't
36 feel confident that he's safe to work with children?

37 A. On a general principle, if I had looked back over that
38 history, I would have made the assumption on the balance of
39 probabilities that he should not be working with children.

40

41 Q. But the only way, having regard to the processes
42 available to you at the time --

43 A. At the time, would be to put all of those allegations
44 to him and invite him to give me a response to them.

45

46 Q. Yes, and I think you agree that, whilst it's not
47 perhaps fair to call on you to design the different model,

1 there should be a different model to at least be used where
2 the person involved is someone who works with children?

3 A. Yes.

4

5 Q. To ensure that, rather than all of the benefit of the
6 doubt in process and timing and procedure flowing to the
7 employee, appropriate weight and priority is given to the
8 safety of children?

9 A. Yes.

10

11 Q. Can I turn then, considering the question further of
12 the Abuse in State Care claims, you were present for the
13 evidence of Ms Clarke and Ms Baker yesterday in which they
14 described the ways in which they during 2020 became aware
15 of the existence of the Abuse in Care records?

16 A. Yes.

17

18 Q. In one case it was literally overhearing someone
19 talking in the next office, I think?

20 A. That was Ms Allen, yep.

21

22 Q. That's right, and then I think Ms Clarke said that she
23 became aware of them because of a conversation she had with
24 a lawyer in private practice who hold her, "Go and look at
25 records"?

26 A. Yes.

27

28 Q. Now, of course, you knew all of that time, presumably,
29 even if it wasn't in the front of your mind, that those
30 records existed?

31 A. Yes.

32

33 Q. But as I understand it, consistent with what we've
34 said earlier, you had an understanding that they weren't
35 records which could be made use of?

36 A. Yes.

37

38 Q. And ultimately a process occurred which led to advice
39 being obtained from the Solicitor-General at the end of
40 2020?

41 A. Yes.

42

43 Q. Which changed the approach that had been in place?

44 A. Yes, and it was - it was a whole-of-government
45 approach, it wasn't just the Department of Communities in
46 particular; there were representatives of Education,
47 Justice, Police attended at the meeting. And I can

1 remember when all of us as one wanted to progress with the
2 matters that were coming out of redress, we were advised
3 that there was a risk in that, in that, at the time we were
4 the only State who were proposing to do that, I'm not aware
5 that other States have shifted to our position, but back
6 then, in 2020, we were the first State to actually start
7 acting on the redress claims for disciplinary purposes.
8

9 Q. And I just want to be clear, because redress can mean
10 a couple of different things --

11 A. That was the National Redress Scheme.
12

13 Q. So, as an aftermath of the National Royal Commission,
14 the National Redress Scheme was put in place to which
15 Tasmania is a participating entity; is that right?

16 A. Yes.
17

18 Q. And so, it appears that in 2019 and 2020 claims
19 started to be made through that scheme which relevantly
20 included allegations that people had been abused at Ashley?

21 A. Yes.
22

23 Q. And a process began, as I understand it, about the
24 extent to which that material could be brought to bear into
25 employment decision-making; yes?

26 A. Yes.
27

28 Q. But separate from that, although related to it,
29 Ms Allen and others became aware of the materials that
30 might be available through the State Redress Schemes that
31 we've already been talking about?

32 A. Yes.
33

34 Q. And, as I understand it, advice was ultimately
35 obtained that led to the conclusion that that material
36 could also be brought into use?

37 A. Yes.
38

39 Q. And that that's what started to happen?

40 A. Yes.
41

42 Q. As I understand it, when that started to happen it was
43 identified that there was still quite a significant number
44 of current employees who were named either in National
45 Redress matters or in the Abuse in State Care claims.

46 A. Yes.
47

1 Q. That must have been horrifying to you?

2 A. Yes, it was.

3

4 Q. Can I ask you when you first became aware of the
5 potential scale of this?

6 A. I would have to go back and look at diaries and
7 things; it was sometime before the end of December. There
8 was a lot of activity in a very short period of time. It
9 would have been towards the end of 2020 where we became
10 aware of the extent of the number of current employees who
11 were implicated from the various redress programs or
12 processes, rounds, however you want to describe it, and the
13 severity of the allegations.

14

15 As we've discussed earlier, I wasn't party to the
16 information in redress, they were all processed at officer
17 level, and it was only at this point that the nature of the
18 substance of the allegations was actually starting to be
19 put in front of me.

20

21 Q. And, as I understand it, you wrote to Ms McLean
22 in September 2020 referring to the fact that a cross-check
23 had been commenced of all Ashley employees against all
24 client files relating to the Abuse in Care Scheme to see if
25 there were allegations against current employees?

26 A. Yes.

27

28 Q. As I understand it from the evidence that we've heard
29 from other witnesses, a big barrier to this cross-checking
30 being done in anything like a timely way was the state of
31 the records, the form that they existed in?

32 A. Yes.

33

34 Q. We've heard some evidence about attempts that were
35 made to get particular budgetary assistance to help with
36 that work - I don't want you to talk about
37 Cabinet-in-Confidence matters - but one might reflect on
38 this being a significant body of work that your department
39 was called upon to give effect to without any additional
40 resources, even though it's really a once in a 100 year
41 event potentially in terms of the kinds of record-keeping
42 investigations that you were being called on to undertake?

43 A. Hopefully it's even longer than once in 100 years.
44 It's difficult to describe the size and scale of the work
45 that had to be done, the number of people that we put into
46 cars to drive around the state to collect files and to scan
47 them in in a way which made them searchable and able to

1 support a cross-checking process.
2

3 But, to pay credit to the two women who sat here
4 yesterday, there was no pause: as soon as - we commenced
5 doing that work before we actually even put the budget bid
6 in, so we started that work using whatever cash surplus or
7 cash reserves we had in the agency, hoping that the budget
8 bid would be successful; when it wasn't we just kept on
9 going because we needed to.
10

11 Q. I understand from something you said a moment ago,
12 Mr Pervan, that you hadn't been yourself aware of the
13 details of National Redress Scheme claims as they were
14 coming in, but that you then became aware of them?

15 A. Yes.
16

17 Q. As I understand it, it was Ms Clarke in her capacity
18 as the Deputy Secretary who was clearing forms for National
19 Redress during this time; is that right?

20 A. I think it changed over time, it moved between our
21 Legal Services officer - we only had one - and Ms Clarke,
22 but she was involved for some of that time.
23

24 Q. So, you weren't being briefed, I take it, for a period
25 of time at least on the nature and seriousness of the
26 claims that were being made; is that what you're saying?

27 A. No, but knowing how Ms Clarke feels about these
28 issues, I think the redress claims she would have been
29 processing or signing off would have related to previous
30 employees and, if she had seen - if and when she'd seen a
31 current employee come across her desk, she would have
32 escalated that pretty quickly.
33

34 Q. And so, am I right then, is it your understanding that
35 a claim in relation to Ira which you referred to the police
36 in February 2020 after it coming through National Redress,
37 was that the first one that you're aware of coming through
38 National Redress in relation to an, at that time, current
39 employee?

40 A. That's the first one I can recall.
41

42 Q. It would be fair to say, wouldn't it, that the bulk of
43 the employees who were later identified as the subject of
44 historical claims, those claims had been made through the
45 state Abuse in Care Schemes?

46 A. I believe so.
47

1 Q. Although in the more recent past, as I understand it,
2 there have continued to be claims made through National
3 Redress as well?

4 A. Yes.

5
6 Q. Were you present in the hearing room for - or are you
7 aware of the evidence that was given by Mr Graham, the
8 Registrar for Working with Vulnerable People?

9 A. Yes, I listened to it.

10
11 Q. And you'll have heard him say that the observation
12 that he made as the person receiving and often seeking
13 additional information about people from the department,
14 that it seemed to be, in his words, business as usual
15 arrangement without appropriate regard being had to the
16 seriousness of the issues and the urgency with which
17 information should be being gathered.

18
19 I asked other witnesses about this as well, but what's
20 your response to that observation that he made from the
21 vantage point that he was in?

22 A. Primarily mine is the same as Kathy Baker's: that's
23 not my recollection at all. And we've had a similar
24 discussion around some of the witnesses that came forward
25 during the out-of-home care hearings. He reported in his
26 evidence that he was gravely concerned, and at no time did
27 he escalate that to me, I'm quite disappointed about that.
28 I would have responded immediately, and certainly, there
29 was a great deal of activity.

30
31 He also made reference to not hearing information for
32 periods of time: that may have been because we didn't have
33 any additional information to give him, we were still
34 investigating. And certainly, where we have any
35 information that we think goes to the safety of children,
36 when we have the information we provide it immediately;
37 it's a routine process.

38
39 Q. So, just to put some of the more specific comments
40 that he made, it was his experience that some requests for
41 information took over a year to respond to. Whatever the
42 reason, do you accept that that occurred?

43 A. I accept that that's his evidence. I am puzzled as to
44 why he didn't escalate that to me.

45
46 Q. He had the observation that there was multiple
47 transfers of responsibility within the Department of

1 Communities for who it would be, who was liaising with him
2 and providing information; do you accept that that was the
3 case?

4 A. Yes.

5
6 Q. What was the reason for those, I think he thought
7 there were four different movements; why did the
8 responsibility for that change?

9 A. So, when I moved from - when I was moved from - the
10 Department of Health to Communities, at that point there
11 was one part-time legal officer who was carrying the
12 workload of about five people, and a very, very small
13 records section.

14
15 It's worth, without breaching Cabinet Confidentiality,
16 going into the history of the formation of the department.
17 So, by government decision the Department of Communities
18 was formed out of the Human Services area of the Department
19 of Health and Human Services and a piece of the Department
20 of Premier and Cabinet, but the decision was that no new
21 resources would be added. So we took a large functioning
22 department, or two functioning departments, and cut chunks
23 off them and moved them.

24
25 There were some shared services arrangements, RTI was
26 one of them, that didn't work well. So, we ended up having
27 to, once again, using the skills of Kathy Baker,
28 restructure our own workforce to identify resources we
29 could commit to RTI.

30
31 So, the reason why things were moving across that
32 period of time for the Registrar was that we went from one
33 part-time legal officer to a more robust records area and a
34 more robust Legal Services branch, and a very hands-on,
35 capable, engaged Deputy Secretary of Children, Youth and
36 Families.

37
38 Q. One of the things that Mr Graham also said, it
39 appeared to him there had been a lack of urgency in
40 appointing investigators for the various ED5 processes that
41 he understands are underway. What's your response to that
42 suggestion? I think it does seem clear from the evidence
43 that there's been a delay; would you agree that that delay
44 is attributable to a lack of urgency or is there some other
45 reason for why, it would appear, there's been a long period
46 of time before some investigations even have an
47 investigator?

1 A. Once again I'd welcome that conversation with the
2 Registrar. I sign the letters appointing the investigators
3 at the same moment I sign a letter authorising an ED5; so
4 that, it comes through as a package. So, if there's any
5 delay, it's only in that assessment phase when the people
6 pulling that information together are trying to put enough
7 substance together to bring it to me to authorise it, and I
8 haven't left an ED5 recommendation on my desk for more than
9 about an hour.

10
11 Q. So, I think the Commission's seen materials suggesting
12 that there have been difficulties in obtaining the services
13 of sufficient numbers of sufficiently qualified
14 investigators to carry out this work; is that right?

15 A. That is true, but whether that delays that package
16 coming up to me to authorise or not, I can't say, I don't
17 have that access to information, but the appointment
18 letters are to specific investigators, so I'm not aware of
19 a delay, I'm trusting the view that's been put to you.

20
21 Q. One of the things that Mr Graham also said is that he
22 had a concern about the lack of continuous disclosure, that
23 is, ongoing disclosure obligations and he recalled that he
24 had made a request to you in your capacity as the Secretary
25 in relation to that; do you recall that?

26 A. Yes, I do.

27
28 Q. What was the step that you took? Was it news to you
29 that there was a concern or a lack of continuous disclosure
30 to that point?

31 A. It was news to me because, as I said, as far as I was
32 aware every bit of information that we thought would be of
33 interest to the Registrar was being sent through, and
34 without wanting to touch on any specific matter that's
35 currently the subject of an ED5, where he perceives
36 withholding, it is more likely attributable - and this is
37 what was told to me - that we have no new information to
38 provide.

39
40 Q. I see. Can I ask on a related point, stepping aside
41 from disclosure to the Registrar, in your substantial
42 statement that you prepared in response to Request for
43 Statement 52, so that's one that you did a few weeks ago -
44 is it time for us to take a break, Mr Pervan?

45 A. No, keep going, please.

46
47 Q. We're going to take the lunch break in about

1 10 minutes but we can take it now, it's a new topic.

2

3 PRESIDENT NEAVE: Q. Actually could I ask one question
4 before we get to that new topic, ask Mr Pervan a question.
5 You referred to reporting to the police on one occasion?

6 A. Yes.

7

8 Q. What is the normal practice in relation to these
9 matters that have been exposed through either the
10 initiation of an ED5 process or information which has come
11 to light in relation to the Abuse in State Care or the
12 National Redress Scheme?

13 A. So, in the past my observation is that part of the
14 assessment process by our staff would have been determined
15 if the information that's been brought forward constitutes
16 a potential crime, and then it would be reported to police.
17 What happens now is that we report any allegation involving
18 child sexual abuse to the Registrar and the police at the
19 same time. So, we don't analyse it, we don't apply any
20 threshold: if it's an allegation, however broad or general,
21 involving child sexual abuse, it gets referred and then the
22 police assess it at their end.

23

24 Q. And that occurs before there's been any examination of
25 the claim in any sort of detail?

26 A. Yeah.

27

28 PRESIDENT NEAVE: Thank you.

29

30 MS ELLYARD: Commissioners, unless there's another
31 question on that discrete topic, can I invite you to take
32 the lunch break now?

33

34 PRESIDENT NEAVE: Yes, we will do that.

35

36 **LUNCHEON ADJOURNMENT**

37

38 MS ELLYARD: Thank you. Commissioners.

39

40 Q. Thank you, Mr Pervan. As before, please do let me
41 know at any time if you feel that we need to break.
42 There's four topics that I want to cover with you: the
43 first one relates to the experiences of a young man who
44 we've been calling Henry, and a review that was ultimately
45 done by the Serious Events Review Team, or perhaps to take
46 up the evidence of yesterday, members of that team into his
47 experiences at the hands of two young boys who we've called

1 Albert and Finn. You're aware of that matter?

2 A. Yes.

3

4 Q. In your statement you've answered some questions
5 arising out of the SERT Review that was done. One of the
6 things that the SERT Review concluded was that an incident
7 briefing provided to you at the time of the incident was
8 misleading. You're aware that that was found?

9 A. Yes.

10

11 Q. Having had the opportunity to know the SERT Review
12 team's conclusion and to perhaps look again at the briefing
13 in the light of what you now know to be the circumstances,
14 do you agree that it was misleading?

15 A. The briefing did - was entitled and did contain the
16 words that it was a potential sexual assault; what it
17 didn't do was provide accurate details as to the full
18 extent of the assault.

19

20 Q. Yes.

21 A. The motive for that I don't want to speculate at, but
22 it was inappropriate, to say the least, and there was a
23 follow-up as a result of the SERT Review over various
24 issues that were raised in the report from the structure of
25 that briefing note right through to the placement policy
26 and the need to change that so that a similar circumstance
27 couldn't occur again.

28

29 Q. So that's an example of a briefing note which, as we
30 understand it, was prepared originally by the then manager
31 of the centre and progressed upwards to you?

32 A. Yes.

33

34 Q. But it would be fair to say, I think, that there was
35 reliance at all levels, including at your level, on what
36 had been written by the Centre Manager being accurate?

37 A. Yes.

38

39 Q. And subsequent events revealed that, at best, there
40 was a minimising and perhaps a lack of appreciation even by
41 the manager himself of the seriousness of what had occurred
42 to Henry?

43 A. I think there are two aspects to that - sorry, I
44 agree, and in two ways: (1) there was at least one if not
45 more essential facts missing, but the other thing, and I'm
46 grateful to the way the questions in the RFS were
47 structured, it reflected a lack of understanding of trauma,

1 and certainly it was not a trauma-informed briefing note,
2 in that, it was very matter of factual, it was on a
3 timeline and it didn't go into the impact that would have
4 had on the young man involved.

5
6 Q. Henry.

7 A. Henry, it didn't go into the impact and what his needs
8 would have been in response following, not just taken to
9 the nurse or allowed to see a psychologist on a visit,
10 there should have been an ongoing relationship
11 therapeutically to support Henry.

12
13 Q. And so, one question that arises: you were being
14 briefed for information, as I understand it, when that
15 incident report was sent up to you, and we now know that
16 some months latter as the result of advocacy from other
17 people, including the clinical psychologist and Alysha, the
18 issue came to the attention of new management, Ms Clarke
19 and Ms Honan, and a SERT Review was commissioned.

20 A. Yes.

21
22 Q. Had you been provided at the time in August when the
23 briefing was first made to you with a fuller and more
24 accurate summary, not just of what had occurred but of the
25 significance of it, do you think you would have done
26 something more than just noting it as you did at the time?

27 A. I would have at least requested an independent
28 investigation, if not through SERT. I think using one of
29 the SERT trained investigators was a very good call because
30 they were available and Mandy and Pam wanted to respond
31 very quickly; but, yeah, there would have been far faster
32 follow up if I had been acquainted with the full facts.

33
34 Q. So, the response that ultimately occurred, that is,
35 the review that Ms Burton did, would have occurred sooner?

36 A. Yes.

37
38 Q. Thinking about the review that Ms Burton did; were you
39 present for her evidence or were you able to watch her
40 evidence?

41 A. Part of it.

42
43 Q. You were certainly present for the evidence of
44 Ms Clarke and Ms Baker yesterday on this topic.

45 A. Yes.

46
47 Q. We've been proceeding on the understanding that the

1 review that Ms Burton did was a "SERT Review" and she gave
2 some evidence that she was surprised and perhaps concerned
3 that her review didn't follow the usual processes of report
4 up to the committee. Yesterday we heard some evidence that
5 it wasn't perhaps a SERT Review but a review done by a SERT
6 member; that distinction strikes me as a fine one but is
7 that a distinction that you are drawing too?

8 A. I would draw it because it's a matter of fact. By the
9 time that Ms Burton was asked to undertake the review the
10 SERT, the team, had been disbanded or returned to their
11 substantive positions. The SERT was pulled together to
12 investigate some specific infant deaths, and from existing
13 resources, we weren't funded separately for it; it
14 developed a set of skills, they were very useful, but we
15 don't have - and I hope this is always going to be the
16 case - we don't have the kind of ongoing workload that
17 would necessitate standing up and maintaining a team like
18 that. So, it was a recognition of the SERT skills and the
19 skills of Ms Burton and of the process, and that's why the
20 documentation refers to it as a SERT Review, because that
21 was the template structure that they used.

22
23 Q. I want to test what you've said, Mr Pervan, about not
24 having enough work for an ongoing stand up SERT Team to do.
25 Some of the evidence that the Commission's had access to
26 over the last seven days, including the evidence of people
27 like Ms Gardiner and Alysha and what's emerged through the
28 evidence of some lived experience witnesses, would tend to
29 suggest that perhaps incidents warranting an independent
30 review by SERT do occur at Ashley?

31 A. Yeah, I agree.

32
33 Q. And you would agree that it would be highly desirable,
34 and this is perhaps partly thinking about looking forward,
35 for there to be available to those managing Ashley a pool
36 of people who have current relevant skills in investigating
37 such matters?

38 A. Yes, I agree, and it would be very much advantageous
39 to have them there and on standby. There are a few issues
40 that in retrospect could have benefitted and I'm sure there
41 will be issues in the future. In an environment where we
42 are working with very fixed resources, that the decision
43 that was made once we finished that matter for the Coroner
44 was that we would pull SERT together as and when needed,
45 rather than having the standing resource there ready to
46 use.

47

1 The SERT was a particular, not only group of people,
2 but it reported through to a committee, and the committee
3 was mentioned yesterday, that wouldn't have been relevant
4 in this case; the committee included the Chief Medical
5 Officer and various other people. So, the processes are
6 robust, the people that undertake the reviews have
7 certainly got the skills to do it; I would take it a little
8 broader if we're looking into the future. It would be
9 really good following from the Safe Families Coordination
10 Unit Model that the government put in place which has
11 worked really, really well, if that process could include a
12 presence from Tasmania Police and any other relevant
13 agency.

14
15 Q. Can I just test your memory about when the SERT was
16 formally dissolved. Ms Burton's evidence and recollection
17 was that that had occurred in May or June 2020, so after
18 she completed the review into Henry's matter. Could she be
19 right about that?

20 A. Yes, but I think - and we were in lockdown at the
21 time, so all of this was happening via phone and email.

22
23 Q. Of course.

24 A. My recollection was that the view was to try and keep
25 the SERT work for the Coroner as a distinct entity, for
26 want of a better word, and this was a piece of work, to use
27 a Tasmanian expression, that was being done on the side of
28 the desk or it was being done as a separate process while
29 the other work was still being concluded.

30
31 Q. So it was a resource that was available to you and so
32 you drew on it?

33 A. Yes.

34
35 Q. Tending to perhaps support the conclusion that it's
36 good to have such a resource available to draw on?

37 A. Yes.

38
39 Q. Thinking about other sources of independent advice and
40 assistance, there were for a time, as I understand it,
41 senior quality practice advisors who could also be called
42 upon to provide assistance in relation to individual
43 detainees at Ashley; is that right?

44 A. Yes.

45
46 Q. SQPA?

47 A. It's a terrible public service thing to turn acronyms

1 into words, but I've only ever heard them called SQPAs,
2 I've never heard the full title.

3

4 Q. There's clearly in the material some reference to the
5 suggestion that in respect of the behaviour of some young
6 people, including someone we've called Ray, a SQPA referral
7 would be useful?

8 A. Yes.

9

10 Q. As I understand it, SQPAs don't exist in the form that
11 they used to; is that right?

12 A. That's correct.

13

14 Q. And that's a decision taken in the recent past as part
15 of a change that I think you gave some evidence about when
16 you appeared before the Commission last time?

17 A. Yes. There are similar roles, just without the
18 cumbersome title.

19

20 Q. But there have been some issues in relation to filling
21 those roles; is that right?

22 A. Yes.

23

24 Q. In practical terms at the moment would it be fair to
25 say that there's been an absence of a source of potential
26 expert advice and support that previously existed that --

27 A. There's a shortage and we're actively trying to
28 recruit to a number of positions. We had a little
29 misfortune in recruitment lately but it's certainly
30 something that's the highest priority.

31

32 Q. Thank you. Can I turn to a different topic. You've
33 been at pains to say - or you've made it clear in your
34 statement that you're not responsible for operational
35 decision-making at Ashley in the sense that you don't take
36 operational decisions?

37 A. Correct, yes.

38

39 Q. Of course, you're responsible for them because you're
40 the Secretary, but they're done by people on the scene
41 pursuant where appropriate to the delegations that we
42 discussed yesterday?

43 A. Yes.

44

45 Q. You'll have heard, and we touched yesterday on the
46 concept of isolation as an example of delegated practices?

47 A. Yes.

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Q. We've had a lot of evidence in the course of these hearings about the previous practice of unit bound or the Blue Program, it's been known by various names: you're aware of that evidence?

A. Very.

Q. You were asked some questions which you answered in Request for Statement 52, so not the most recent one but the previous one, about the Blue Program and your answer was that it wasn't a formalised or approved program, not contained in any policy or procedure documents, but did have some level of acceptance amongst Ashley staff as being operationally utilised; do you recall that was the evidence that you gave?

A. Yes.

Q. And that was your understanding, I take it, at the time of your statement?

A. From the advice given, yes.

Q. Is it still your understanding that there wasn't ever a policy or procedure document that related to it?

A. My understanding is that there was a draft that was circulated amongst some staff, but that there was never a formal policy issued by the Director or the Deputy Secretary.

Q. But certainly we had some evidence from Ms Gardiner when she gave her evidence at the beginning of the week that she worked on documentation that, to some extent at least, was formalising a Blue Program or a unit bound program?

A. She was drafting, yes, but as we've discussed in other evidence it was non-compliant, it didn't meet the legislative requirements of isolation.

Q. And so, this is an example, isn't it, of operational decision-making and even policy making at the local level that, if drawn to your attention, you would be concerned about and would take action about?

A. Yes.

Q. But which didn't come to your attention at the time?

A. Yes.

Q. What processes would give you any comfort, as I take

1 it you have, that someone going kind of off reservation and
2 drawing up policies of that kind now would come to your
3 attention?

4 A. Once again, this comes down to the skills and
5 competence of the people in the chain of command and what
6 we've seen, what we've actually - the changes over the last
7 two years, is that, people with the leadership and
8 knowledge skills of the likes of Pam Honan have undertaken
9 a number of policy reviews, have initiated that access to
10 legal advice, have stopped very quickly processes that
11 aren't compliant with legislation or that just don't
12 reflect the practice framework and have replaced them with
13 ones that do. So, getting the right people into these
14 jobs, and it almost goes back to the discussion we had
15 earlier on the Harker Report and Noetic: having a great
16 report, even having really good legal advice isn't enough,
17 you actually have to have the right leadership on the
18 ground who understand what they're looking at and can then
19 provide me with the assurance that it's all sound and
20 appropriate.

21
22 Q. Would you agree that the unit bound or Blue Program
23 was a form of isolation?

24 A. Very hard not to agree with that.

25
26 Q. And therefore not something that should have been in
27 existence?

28 A. Yes, I agree.

29
30 Q. Without approval through the proper use of delegations
31 in accordance with isolation policy?

32 A. Yes.

33
34 Q. We've heard evidence that in the recent past for
35 reasons connected in part with staffing levels, children
36 have been required, not for disciplinary reasons but for
37 other reasons, to be subjected to restrictive practices and
38 no doubt you're aware of that?

39 A. Yes.

40
41 Q. And there's been periods of time, in fact potentially
42 in the very recent past, where children have had to be
43 unit-bound, that is, kept in their units, if not their
44 rooms, for nearly all of the day, and no doubt that
45 concerns you?

46 A. Deeply. And not just me, it concerns, well, the
47 acting Deputy Secretary is deeply concerned with it,

1 Narelle Butt, and it was deeply concerning to Pam, but it
2 was purely because staffing was under such pressure that we
3 couldn't safely bring them out for their normal routines.
4 But to their credit, and this applies to Stuart and Fiona,
5 they did come up with some incredibly flexible and creative
6 ways to maximise the time each young person was out of
7 their rooms, even when we had very minimal staffing on
8 site.

9
10 Q. Are you aware of evidence or opinions that were
11 expressed by Mr Morrissey, the former Children's
12 Commissioner, and I think ultimately agreed to by a couple
13 of other witnesses, that restrictive practices at Ashley
14 which keep children in their rooms for such prolonged
15 periods could be torture, within the definition as used in
16 the optional protocol? Firstly, are you aware that that
17 evidence was given?

18 A. I'm aware that that evidence was given, and in a small
19 way I'm a little conflicted because, I would agree with
20 Mark, I recruited him and he's an old friend of mine.
21 Without wanting to go to a specific case, only because I
22 don't have that detail in front of me, as I understand -
23 and it's a superficial understanding - the definition of
24 "torture" in that document goes to intent, and there was,
25 I believe, looking at the past, a use of restrictive
26 practice to - it would be argued by the staff involved it
27 was used as a disciplinary measure, but yet the intent was
28 to cause people to feel bad, it wasn't for their safety, it
29 wasn't for any other purpose but to punish them.

30
31 Q. Yes, so I think you're drawing the distinction that
32 perhaps no-one at Ashley right now is guilty of torturing
33 children in the sense that it's not their intention, but
34 the point that Mr Morrissey was making was that in
35 practice, in terms of the effect on the young people who
36 are subject to staff shortage-induced restrictive
37 practices, the effect on them could be properly described
38 as torture; would you have a response to that?

39 A. I would. There are two profound differences between
40 isolation or restrictive practice being used as torture and
41 what we've seen recently. One is that cognizance that it's
42 damaging to the wellbeing of people to have them in
43 isolation, and that in this instance when we haven't been
44 able to get the young people out for the time that they've
45 required, the staff there, up to and including Ms Honan,
46 have explained to them what the context is, why it's
47 happening and what we're doing to try and fix it. So, they

1 haven't just been locked in their rooms and not told
2 anything; it's been explained to them that it's only
3 because we're short of staff and we're doing everything we
4 can to get them out of their rooms, and as soon as we've
5 had more staff on deck they've been back to normal,
6 programs and access to services and activities.

7
8 Q. Can I ask you - turning to my second-to-last topic,
9 Mr Pervan, and this goes to some of the findings that might
10 be open to the Commission, and in asking you these
11 questions I want to make a couple of things clear.
12 Firstly, it's clear that in your role currently as the Head
13 of Agency you may be called upon to make decisions about
14 the conduct of individual employees, and it's important
15 that you not say anything to be perceived as prejudging any
16 such matter: you agree with that?

17 A. Yes.

18
19 Q. And so, you're not in a position, and indeed nor is
20 the Commission, to resolve the truth or otherwise of
21 individual allegations against individual people?

22 A. Yes.

23
24 Q. But you would be aware, because a lot of it's been
25 provided to the Commission by your department, of the very
26 substantial body of evidence of complaints and allegations
27 that have been made over time and through various means
28 alleging sexual abuse at Ashley?

29 A. Yes.

30
31 Q. And you're aware in particular of the evidence that's
32 been given by former detainees this week: yes?

33 A. Yes.

34
35 Q. And from other witnesses who have described their
36 observations into the very recent past of children being
37 harmed, whether by harmful sexual behaviours or other
38 inappropriate and sexually abusive practices?

39 A. Yes.

40
41 Q. And so, the Commission's role of course is very
42 different to the role that you hold as the Head of Agency;
43 would you accept that?

44 A. Yes.

45
46 Q. And so, there's ways in which the Commission can
47 consider evidence and make conclusions about the state of

1 affairs at Ashley on a more global level than is free for
2 you under any individual ED5 process?

3 A. Yes.

4
5 Q. So, with all of those parameters in mind, would you
6 agree that, having regard to all of the evidence that's
7 available, it's open to the Commission to find that there
8 has been ongoing sexual abuse of some detainees by some
9 officials at Ashley over the last 20 years?

10 A. Yes, I would.

11
12 Q. And that, whether we describe it as a "pattern" or
13 "repeated conduct" or whatever, nevertheless it's clear
14 that it's not isolated incidents; would you accept that?

15 A. Yes.

16
17 Q. That there has been a widespread insurance amongst
18 some detainees of abusive behaviour, including at the hands
19 of some officials?

20 A. Yes.

21
22 Q. And it's in that context that you have offered an
23 apology in your statement --

24 A. Yes.

25
26 Q. -- which I want you to give the opportunity to make
27 out loud if you would like to.

28 A. Thank you, and I appreciate the opportunity to provide
29 the apology. And I spent some time on putting these words
30 together, so please excuse me if I read them off the page.

31
32 Q. Of course.

33 A.

34
35 *I wish to acknowledge the survivors of*
36 *child sexual abuse and any other forms of*
37 *abuse that have occurred at Ashley Youth*
38 *Detention Centre and its predecessors.*

39
40 *I have and continue to be personally deeply*
41 *impacted by the survivors' experiences at*
42 *Ashley and as Secretary of the department I*
43 *sincerely apologise to each and every young*
44 *person that Tasmanian Government*
45 *Departments did not provide safe and secure*
46 *care for at Ashley.*

1 *I acknowledge that the trauma that*
2 *survivors suffered has and will continue to*
3 *cause severe pain - physical, mental,*
4 *emotional and cultural.*

5
6 *I also acknowledge that your pain will be*
7 *lifelong, that the abuse impacts who you*
8 *are, who you wanted to be, and how you feel*
9 *about yourselves and others.*

10
11 *I acknowledge that trauma has been*
12 *transmitted into your relationships with*
13 *your families, including your children, and*
14 *that that pain is lifelong and I deeply*
15 *regret it.*

16
17 Q. Thank you, Mr Pervan. There's one final topic that I
18 wanted to raise with you, and that's about the future. We
19 asked you some questions in each of the two most recent
20 requests for statements, which you've answered, about the
21 extent to which planning is underway for what's going to
22 replace Ashley. The government's been very clear that
23 Ashley is to close in what, to my calculations is just a
24 little over two years from now.

25
26 The Commission heard from Ms Honan last week, and
27 perhaps somewhat surprisingly when she was asked about the
28 state of work towards the new centres she indicated that
29 she wasn't aware of the work and that she wasn't involved
30 in it, which struck us as, can I suggest, seems odd given
31 the experience and competence that she obviously has in the
32 role right now.

33
34 So, with that as a backdrop, can I ask you: what's the
35 current state of planning towards where children who would
36 be in Ashley two years from now would be moved to when
37 Ashley closes, as the government has said it will?

38 A. Thank you. So, firstly, there is every intention to
39 involve Pam Honan, particularly when she returns from
40 leave. What's been happening at the moment is that the
41 project team within the department has been working very
42 diligently with Noetic and with the Australian Childhood
43 Foundation more recently on developing the model of care
44 and the "functional brief", is the expression used, that
45 will then inform a design for the in you facilities.

46
47 The reason why Pam hasn't heard from them for a little

1 while was our observation that she was pretty well tied up
2 with operational matters in preparing for the Commission,
3 and that's the only reason why she hasn't been engaged to a
4 greater extent. But certainly her knowledge and
5 experience, and particularly across multiple systems, is
6 second to none, so the intention when she comes back is to
7 have her play a greater role.

8
9 We also were waiting for the commencement of the new
10 Executive Director of Youth Justice reform to bring all of
11 these individuals and the group, the team together to see
12 where we were at in the detailed compilation of the plan
13 forward and the functional brief, and to then engage with
14 Pam about getting her direct feedback.

15
16 Q. Thank you. So, that certainly explains the way in
17 which you're going to take advantage of her expertise, but
18 as I understand it the Executive Director Youth Justice
19 Reform's only recently commenced his role?

20 A. Yes, about two weeks ago.

21
22 Q. And as I understand it, and I want to understand the
23 extent to which, as far you're aware, plans for what's
24 going to replace Ashley are linked to and dependent on the
25 outcome of the Youth Justice Blueprint that's been
26 disseminated in at least one form and I think more recently
27 in another form?

28 A. Yes, they're parallel pieces of work.

29
30 Q. But are they part of the same piece of work? Because
31 one observation that might be made is that two years isn't
32 very long to find a new place for Ashley, whereas the
33 Blueprint might be said to have larger and longer term
34 timeframes?

35 A. That's a very good point, and that's why they're being
36 done in parallel. So, there is - sorry for speaking with
37 my hands - the Blueprint is the longer term strategy that
38 covers the whole Youth Justice service, but from that, and
39 has to be synchronised or harmonised with the wider
40 Blueprint, is the functional brief for the detention centre
41 or centres that come out of that.

42
43 And the process to date, particularly with Noetic, has
44 been particularly looking at international models to see
45 where we can draw down from an international evidence base
46 what the service needs to look like and how it needs to be
47 structured to have the greatest benefit in terms of

1 trauma-informed therapeutic care for young offenders so
2 that they're happening at the same time.

3
4 Q. As I understand it, the evidence that Ms Mitchell gave
5 from the Australian Childhood Foundation was that there's
6 been preliminary discussions about a possible role; would
7 you accept that? Possible involvement of the ACF in
8 determining the practice framework?

9 A. Yes, and that was commenced some weeks ago. There
10 have been delays on both sides for private reasons that I
11 don't think I should divulge, but they are very much
12 involved. When Janise was down, she met with the new
13 Executive Director; we're proceeding with that work, so
14 that's been enabled, so it's gone beyond preliminary
15 discussions now to an active piece of work --

16
17 Q. Sorry, go on.

18 A. My intention with engaging them is that I wanted to
19 provide an independent assessment of the current state at
20 Ashley, both for the Executive Director and for the new
21 Secretary of the service; an appraisal of where we're at
22 with the greater reform journey, but also to give them a
23 bit of roadmap of how do we get from where we are today to
24 where everyone wants to be and what do the steps in that
25 look like?

26
27 Q. One of the things that Ms Honan said when invited to
28 reflect on the timeframes by the Commissioners last Friday
29 was that, I mean, two years and a bit is a very short space
30 of time when one considers how much she's had to try and
31 get done in the last three years. Would you accept that
32 there's really not much time at all between now and when
33 Ashley's closing to do all of the very detailed work that
34 you've just described?

35 A. Absolutely. And there is two parts; there seems to be
36 a lot of two-part answers. The target that the former
37 Premier set us was, to be kind, very, very ambitious, but
38 we're only gonna get one chance to do this in a generation
39 and, up to and including the Minister and the current
40 Premier, everyone wants to did it right. If it was just to
41 design two detention facilities, we could probably find
42 plans for those off the internet and we could deliver to
43 the timeline a building with a fence and a sally port gate
44 at the front and say that we've done the job, but we're
45 actually putting the effort into making sure we're doing it
46 right, notwithstanding that we're very aware of that
47 compressed timeline. But if doing it right means that we

1 won't meet that timeline on the knocker, that's something
2 that we'll take to government as early as we can and let
3 them know why it's taking a bit longer; that's why it is,
4 because we're trying to do it right.

5
6 Q. Yes, and so I take it then from what you're saying is
7 that the idea is that, although there are parallel
8 processes rather than the one process, nevertheless the
9 intention is to keep them in step with each other --

10 A. Yes.

11
12 Q. -- so you're not going to go ahead and build the
13 replacement facilities other than as part of a joined up
14 Youth Justice solution?

15 A. Yes.

16
17 Q. And so in practical terms what that may mean is that
18 Ashley can't close in two years and a month because its
19 replacement facilities won't be ready yet. That's a
20 possibility, I take it, from what you've said?

21 A. That's a possibility but that's not what we're
22 planning for; we're planning on delivery. And it will be
23 helped by a really, really well-informed functional brief
24 that goes to a smaller facility, that's based on
25 predictable fewer numbers coming through the system. So we
26 are still hopeful that we will deliver this in time.

27
28 Q. Part pardon me a moment, Mr Pervan. I think those are
29 the matters that I have for Mr Pervan, Commissioners, but
30 I'm conscious that before I excuse him from the witness box
31 there may be some matters of clarification or detail that
32 you wished to raise?

33
34 COMMISSIONER BENJAMIN: Q. Yes, I have a couple of
35 questions, if I may. In your evidence earlier today,
36 Mr Pervan, you talked about the PIP Act, if that's the
37 right acronym --

38 A. Yes.

39
40 Q. -- being a blockage to sharing some information; is
41 that right?

42 A. Yes.

43
44 Q. Is that where, I think we heard yesterday or the day
45 before, the notion of double jeopardy may have come in? Or
46 am I conflating two matters? I know there's no double
47 jeopardy other than in crime, but I'm talking about the

1 notion.

2 A. Yes.

3

4 Q. Only a lawyer would say that, by the way.

5 A. I think the matter of double jeopardy was raised with
6 me - it was raised with me, but I think it was raised in
7 evidence by Ms Allen, and that was in relation to
8 considering, as we were talking earlier, considering
9 matters that had been through an ED5 before and had been
10 determined and either found not proved or have a
11 disciplinary penalty - or sanction, sorry, applied.

12

13 The PIP Act is really just about communication to
14 complainants, and in all sorts of ways that restricts us
15 from what - and I'm sorry to keep going back to old roles,
16 but what's known in the Health system as "open disclosure",
17 where you are enabled to share facts with a complainant
18 about particular clinical matters, whereas the PIP Act
19 actually confines the extent of the information, and
20 sometimes greatly confines the information, that we can
21 pass to a complainant without the consent of the subject of
22 the complaint.

23

24 PRESIDENT NEAVE: Q. So, the issue would be in that
25 context, I think, a situation where a complainant is
26 unaware that other complaints were made about the same
27 person?

28 A. M'mm, or even the full details of the investigation
29 that we've undertaken into their own complaint.

30

31 PRESIDENT NEAVE: Yes.

32

33 COMMISSIONER BENJAMIN: Q. My second question is: you
34 talked earlier today about cutting your cloth to meet
35 the --

36 A. I've forgotten the full expression, I'm sorry.

37

38 Q. Yes. So have I, so that makes two of us. But what
39 you're saying is that the way the current but
40 soon-to-be-broken-up department was created, for historical
41 reasons, meant that it didn't have the funds that it really
42 needed to bring about significant change. Is that the
43 thrust of your evidence?

44 A. It didn't have the funds to meet our ambitions. I'll
45 put it that way. We would have loved to have done more but
46 we understand, as Kathy Baker said, it's a heavily
47 contested budget environment, so we took what we were given

1 and made the most of it by creative means.

2

3 Q. And finally, just a bit out of left field: throughout
4 this Commission so far we've looked at the importance of
5 the office of the Children's Commissioner?

6 A. Yes.

7

8 Q. And I think the current Commissioner's office is
9 funded out of your department?

10 A. We hold the funds, but the funds are determined
11 through the same budget process.

12

13 Q. For the sake of not only the reality of independence,
14 but the perception of that, do you have a view as to
15 whether it ought to be separately funded so that children
16 would know that it's not part of a single department?

17 A. I think there is merit in terms of the appearance of
18 independence and the perception of it, of independently
19 funding it: I would - for my part, I would encourage that.
20 The only problem is that I've been able to support the
21 Commissioner with additional funding from my budget in all
22 sorts of --

23

24 Q. Yes, you gave evidence about that yesterday.

25 A. But that was the one that affected my ability to
26 photocopy and present documents, but there have been
27 broader ways; I've been able to provide funding for them
28 for all sorts of things up to and including employee
29 assistance for the Commissioner and her staff. So there is
30 a benefit to having it attached to a broader budget entity,
31 but I think for all sorts of reasons, you know, there might
32 be alternatives to that: perhaps having some budget
33 mechanism to fund all of the independent bodies, the
34 Ombudsman and so on, together so that they can be truly add
35 arm's-length of the bureaucracy.

36

37 COMMISSIONER BENJAMIN: Thank you.

38 A. You're welcome. Thank you, President.

39

40 COMMISSIONER BROMFIELD: Q. I just had one question,
41 Mr Pervan. You've spoken about the, not just the
42 leadership skills of Ms Clarke and Ms Honan, but the
43 expertise that they brought to the role. Bearing that in
44 mind as a new department's being formed, do you have any
45 advice or reflections as to whether there needs to be
46 leadership with content experience that sits at the top
47 there within the Dep Sec level?

1 A. That's really for the new Secretary to determine.
2 There are substantial leaders in the Children, Youth and
3 Families group, and some really amazing emerging leaders;
4 I won't embarrass them by naming them, but I do know that
5 you've heard from them and they've given evidence.
6

7 I think that that focus, though, on identifying people
8 with leadership skills, is something which I needed to do
9 more formally. I was incredibly lucky to arrive at the
10 Department of Communities after my predecessor, Ginna
11 Webster, had made sensational appointments with Mandy and
12 with Pam, as well as of course Kathy Baker and others. So,
13 while I'll take credit for the most recent appointments,
14 the reason why the Department of Communities had such a
15 robust executive team that really did perform as a team
16 goes down to Ginna Webster and her selections. In terms of
17 the next generation coming through, I think right down to
18 even the sort of operational shift managers - they have a
19 different title to that - but people at that level at
20 Ashley, we should be looking to doing leadership
21 development that level so they understand what it is to get
22 people to move to change their culture or to at least adopt
23 a more contemporary and trauma-based or trauma-informed
24 culture.
25

26 Q. Perhaps if I put it slightly differently so that I'm
27 not asking you to tell the incoming Secretary your
28 thoughts. Would you agree that it's helpful to the
29 Secretary to be able to benefit from both people who hold
30 both practice expertise and leadership?

31 A. Absolutely.
32

33 COMMISSIONER BROMFIELD: Thank you.
34

35 PRESIDENT NEAVE: I have no further questions. Thank you
36 very much, Mr Pervan. You've had a long day, and yesterday
37 too, so thank you very much indeed.

38 A. Thank you, President.
39

40 MS ELLYARD: Commissioners, can I ask you to stand down
41 for the afternoon break now and then we will resume?
42

43 **SHORT ADJOURNMENT**

44

45 MS ELLYARD: Thank you, Commissioners. We now draw to a
46 close this part of the hearings which was focused on the
47 Ashley Youth Detention Centre.

1
2 The evidence that you've heard over the last seven
3 days has highlighted the many systemic failures at Ashley
4 that have allowed the abuse of children to occur, not only
5 in the past, but during the entire life of the Ashley Youth
6 Detention Centre from its inception in 2000 up until today.
7

8 We've heard evidence from victim-survivors and their
9 family members who courageously came forward to share their
10 experiences and I'll return to their evidence in more
11 detail.
12

13 We've heard from previous employees of Ashley who
14 reported allegations of child abuse and advocated for the
15 safety of children at Ashley. Ms Gardiner and Alysha
16 provided remarkably similar accounts of concerns about the
17 safety of children as recently of 2019 to 2020.
18

19 Their concerns were echoed by Mr Morrissey and
20 Ms Burton, who provided an outsiders' view of Ashley over
21 different time periods.
22

23 All of those witnesses came forward to ensure that no
24 other child is harmed at Ashley or in Youth Detention
25 generally. To all of these witnesses we express our thanks
26 for your trust in the Commission and its work and your
27 determination to change the system.
28

29 We acknowledge the various witnesses who currently
30 work at Ashley who have provided evidence and assistance to
31 the Commission. Operational staff described the day-to-day
32 difficulties and challenges of Ashley right up until this
33 week. Unfortunately, those difficulties and challenges
34 appear much the same as those identified in numerous
35 reports provided to government over the past 20 years:
36 staff shortages, lack of training, lack of support from
37 management.
38

39 Mr Watson, Mrs Atkins and Ms Honan all described what
40 they saw as a cultural change in the last 18 months and
41 their efforts to work to create that change whilst noting
42 that there's more to be done. Ms Clarke, while reflecting
43 on the findings of the 2020 report into the conditions,
44 culture and attitudes of staff at Ashley, said that it
45 shows the gravity that's required in the change process.
46

47 Over the course of the hearings you've heard Ashley

1 described as a "gladiator pit", "a war zone" and "out of
2 control". However it's described, Commissioners, it's
3 clear that Ashley has harmed and continues to risk harming
4 children, causing them harm on a systemic and ongoing
5 basis. As we've said at the start of these hearings,
6 there's a clear link between the culture and practices of
7 an institution and the risk of sexual abuse occurring in
8 that institution.

9
10 The evidence this week is directly relevant to the
11 Commission's role of considering the management of risk of
12 child sexual abuse at Ashley and how institutions like
13 Ashley should respond properly when allegations of child
14 sexual abuse are raised.

15
16 We heard evidence on Wednesday that there were, as at
17 that time, 11 children on site at Ashley, 10 on remand, one
18 who was serving a sentence. The youngest of those children
19 was only 11 years old. Five of the 11 children identified
20 as Aboriginal or Torres Strait Islander, one of them was
21 female.

22
23 We heard from Mr Morrissey, the former Commissioner
24 for Children and Young People in Tasmania that most, if not
25 all, of the children and young people at Ashley have
26 significant developmental disorders, have suffered lots of
27 trauma from birth right through to their admission to
28 Ashley. It's critical that any model of detention for
29 Ashley recognises the complex backgrounds and needs of
30 these children and provides a therapeutic, trauma-informed
31 environment in practice not just in words.

32
33 The evidence suggests that under a good therapeutic
34 model of care a child or young person entering Ashley would
35 be entitled to expect certain things about the way they
36 would be cared for there. They would be entitled to expect
37 that they're only detained as a matter of last resort and
38 if they're sentenced for a crime, not just because they
39 don't have an address for bail.

40
41 They should be of an age where it's reasonable that
42 they're held responsible for their crime. They're only
43 searched if there's genuine reason to do so and in
44 accordance with international and national standards that
45 protect and recognise the rights of a child.

46
47 They are entitled to expect that they're placed with

1 other children or young people who are appropriate to their
2 age, gender and other personal circumstances. They're
3 entitled to expect that they would be kept healthy, that
4 they felt safe, supported and protected with the
5 opportunity to learn, to develop positive behaviours and
6 relationships and have the chance to thrive.

7
8 They're entitled to expect that they'd be cared for by
9 well trained staff who understand and can respond to their
10 needs and who are themselves supported by management.

11
12 They're entitled to expect that they have access to
13 trusted adults inside and outside the centre who will
14 listen to and believe their concerns, including about child
15 sexual abuse, and critically take all appropriate action in
16 response.

17
18 They're entitled to expect that their diverse needs
19 and specific vulnerabilities will be recognised and
20 supported and that their cultural needs are met.

21
22 It's particularly critical that Aboriginal children
23 and young people are supported to maintain connections to
24 their culture and communities and have access to Aboriginal
25 workers and community members.

26
27 All of those conditions, if met, would provide an
28 appropriate environment for children and young people and
29 assist in preventing, identifying, reporting and responding
30 to the risks of child sexual abuse or to child sexual abuse
31 itself.

32
33 It would create a context in which management and
34 staff could proactively prevent and manage the risk of
35 child sexual abuse.

36
37 It would create an environment in which children and
38 young people could safely disclose complaints of child
39 sexual abuse without facing risk either from staff or other
40 detainees for speaking up. Their wellbeing would be the
41 paramount consideration.

42
43 Their complaint would result in an immediate and
44 comprehensive response that prioritises managing the risk
45 of harm to children and young people rather than
46 prioritising and focusing on a particular staff member's
47 employment. Any investigation into their complaint would

1 be commenced and concluded in a timely manner. Any action
2 arising from such an investigation would also be actioned
3 in a timely manner.
4

5 In order for that to be the system we have, the system
6 needs to provide wrap-around services for the child during
7 their time in detention and ensure continuity of care
8 during the transition in and out of detention.
9

10 As Mr McGinness said:

11
12 *From the moment a young person comes into*
13 *custody, we should be thinking about and*
14 *planning for their eventual release.*
15

16 There needs to be a therapeutic system, not a punitive
17 one.
18

19 What does a therapeutic system mean? It means that
20 the physical structure and facilities at the detention
21 centre would be designed to support rehabilitation and
22 recovery.
23

24 It would include direct access to adequate healthcare
25 as well as support services to address a child's underlying
26 reasons for offending, including consistent mental health
27 support and treatment and alcohol and drug services.
28

29 In a therapeutic system the detention centre wouldn't
30 be remote and isolated so that the child can maintain
31 access to family and community networks and appropriate
32 Community Services to facilitate their rehabilitation.
33 Children would have consistent and meaningful access to
34 education. The facility would embed the National
35 Principles for Child Safety Organisations and comply with
36 international Human Rights standards.
37

38 Upon release, children and young people would have
39 access to stable accommodation, be enrolled in school, and
40 have continued access to the support services they need.
41

42 The culture of the system wouldn't be dependent on
43 who's in specific roles: all staff would be child-centred
44 and working towards a shared purpose. Those staff would be
45 safe at work and have adequate clinical supervision,
46 support for vicarious trauma and an engaged and supportive
47 management team.

1
2 In this context everyone in the Youth Justice System
3 would be vigilant to the risks of child sexual abuse at any
4 detention centre; they would encourage complaints and
5 reporting, acknowledging that bad things can happen even in
6 good systems and they would be willing to act quickly and
7 respond appropriately to ensure the safety of children.
8

9 Many former and current Ashley employees and
10 Department of Communities witnesses referred to Ashley as
11 having "a dark past". There was reference to the abuse
12 that is known to have occurred in the Ashley Boys' Home or
13 at Wybra Hall. Importantly, you have heard evidence from
14 victim-survivors and their families that that dark past is
15 not just in the past.
16

17 The stories of physical and sexual abuse that you have
18 heard cover the period from the creation of the Ashley
19 Youth Detention Centre in 2000 up until as recently as a
20 year ago.
21

22 On the first day of the hearings Simon told the
23 Commission of the strip-searches that he endured at Ashley.
24 He recalled an incident where he refused to be searched and
25 the youth workers wrestled him to the ground, pulled his
26 bottom cheeks apart and then put him in isolation. He
27 spoke of how violence was commonplace at Ashley.
28

29 He described how youth workers would watch the
30 children shower. He spoke of how he wanted to tell his
31 story because of his friend who died in detention. He
32 recommended that Ashley be torn down and not turned into an
33 adult prison because people who are now adults would have
34 to suffer being detained in the place where they had been
35 abused as a child.
36

37 Warren told his story through his statement which was
38 read to you, a story of continual sexual abuse by three
39 youth workers when he was aged from 14 to 18. He described
40 the abuse occurring during strip-searches and within his
41 room. He told you his medication would be withheld until
42 he performed sexual acts on these guards. He never
43 complained for fear of further abuse and because of threats
44 to his family.
45

46 He said:
47

1 *They would tell me that no-one would*
2 *believe me anyway because I was just a*
3 *little criminal. I didn't want to say*
4 *anything because I was afraid of what they*
5 *could do.*

6
7 Warren's experiences at Ashley have left him with
8 mental health and substance abuse issues. He doesn't trust
9 anyone and is extremely protective of his own children. He
10 recommends CCTV cameras be put up everywhere, there be
11 better training for workers and a safer way to raise
12 complaints.

13
14 On day two of the hearings we heard from Jane whose
15 daughter, Ada, was diagnosed with alcohol problems at the
16 age of 12 and was skipping school. Jane sought help from
17 the Department of Education but, instead of helping with
18 school re-engagement, the department said not to worry
19 about schooling and instead concentrate on dealing with
20 Ada's problems. This was a green light for Ada to drop out
21 of school and her alcoholism increased.

22
23 On the advice of the department, Jane agreed that Ada
24 could be placed on an interim wardship. She believed the
25 state would help. But the state sent Ada to Ashley under
26 restraint, at the age of 12, even though she hadn't
27 committed a crime.

28
29 Jane was conscious of not telling Ada's story for her,
30 but Jane is aware that while Ada was in Ashley there were
31 older children in the same facility and she had to fight
32 boys off. Jane said she only wanted help for her daughter,
33 including for her to get an education. Ada and Jane are
34 still working through the trauma of Ada's experiences at
35 Ashley.

36
37 We also heard on the second day from Eve who spoke of
38 the extraordinary lengths she went to as a mother to ensure
39 that her son, Norman, was receiving proper medical care for
40 his mental health while he was living at Ashley. She tried
41 speaking with the medical team at Ashley herself, then
42 enlisted the help of her son's GP, then the help of an
43 Opposition Minister, the Commissioner for Children and an
44 advocate. She said she was putting up red flags everywhere
45 and people just weren't listening. She said:

46
47 *I spent most of my nights sitting up trying*

1 to figure out ways to help my child.

2

3 She would call him and visit him regularly but over
4 time Norman would stop telling her things and requested
5 that she stop visiting. Later she found out that, for
6 every attempt that she made to help Norman, he would be
7 punished, including through isolation. He was also cavity
8 searched every time she came to visit.

9

10 She described how her son was a completely changed
11 child upon release. She said:

12

13 *He didn't act like he did anymore, he*
14 *wasn't the same person. He'd been through*
15 *so much trauma ... it's like throwing a*
16 *child into war. It's like you put someone*
17 *in a jungle and you've got to survive.*
18 *They'll find a way to survive, but he came*
19 *out a different person.*

20

21 Reflecting on the impact of him being in Ashley, she
22 lamented that Norman was:

23

24 *... a child that still could have been*
25 *turned around and had a future but they*
26 *changed that and his future has been pretty*
27 *awful.*

28

29 On day three of the hearings we heard from Erin who
30 told us about being the only female at Ashley when she was
31 remanded at the age of 14 for stealing a packet of Doritos.
32 As soon as she entered Ashley she was sexualised by the
33 youth workers and the detainees. She was a victim of a
34 serious sexual assault when left unsupervised with 10 male
35 detainees. She was forced to give handjobs to male
36 detainees while youth workers looked on and did nothing.

37

38 She said that, "Saying that a Youth Detention Centre
39 is therapeutic-based is not enough". She said:

40

41 *Ashley had what was supposed to be a*
42 *therapeutic-based system when I was there.*
43 *The programs where I was made to give the*
44 *boys handjobs were part of this*
45 *therapeutic-based system.*

46

47 Instead of stopping the abuse, she was placed on the

1 pill. She was regularly strip-searched by male youth
2 workers and watched in the shower, describing the staff as
3 "a pack of animals". She couldn't complain due to the fear
4 that things would get worse. She was humiliated and
5 degraded every day, not provided a bra or access to
6 tampons.

7
8 Erin's experience caused her to go down a massive
9 spiral of alcohol and drugs, she said, and she is still
10 dealing with the trauma of what happened to her.

11
12 On day four we heard the most recent in time of our
13 stories, that of Max. Max described how he was first sent
14 to Ashley when he was 12. He described sexual abuse and
15 violent assaults by other detainees, all of which were
16 preventable. Max told us that he was moved to a unit
17 despite his warnings to the youth workers that he'd be
18 bashed. He was subsequently savagely beaten by another
19 detainee after he refused to suck that detainee's penis.
20 He said that he would be bashed by the guards in places
21 where there were no cameras, and he spoke about aggressive,
22 invasive strip-searches. He never complained because he
23 was told no-one would believe him.

24
25 He gave evidence of the many occasions he tried to
26 have his voice heard in relation to his placement and
27 wellbeing, but the youth workers never listened. He told
28 you about one occasion where he asked a worker to leave his
29 room and said that, if he didn't leave he would hit him.
30 The worker wouldn't listen, Max lashed out and was then
31 beaten by the worker.

32
33 Reflecting on this, Max said:

34
35 *The way they always say ... if you've got*
36 *something, they say talk about it ... they*
37 *say "talk about stuff before you do*
38 *something", like, "just try and talk about*
39 *it, talk before you use actions". So, I*
40 *tried it and it just didn't work, so there*
41 *was nothing else for me to do.*

42
43 He said he was happy to go to Risdon Prison because
44 the conditions there were better. He said:

45
46 *Ashley will never change if the youth*
47 *workers remain.*

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He said:

What's the point in making all these new centres? It's not the centres that does the stuff, it's actually the staff. If there's even some of the old staff, they could do the same thing.

Max also alleged that he had been bribed by an Ashley staff member in relation to his engagement with this Commission. That part of his evidence is contested. You've heard evidence from the relevant staff member and another witness that provide different accounts of those events and those matters will continue to be considered, including through seeking further submissions if required.

On day five we heard from Charlotte who was in Ashley on and off between the ages of 12 and 15. During this time she was sexually assaulted on multiple occasions by workers and by other detainees. One worker, Edwin, would talk dirty to her, tell her she was pretty and inappropriately touch her. On one occasion she was left unsupervised with four male detainees and subject to an horrendous rape.

She couldn't complain because, as she said:

The boy that did it had been in Ashley for a long time. He was liked by the workers.

She said that there was no rehabilitation at Ashley, she never received schooling when she was there, and is not now able to read and write. As a result of her experience, Charlotte said she doesn't like anybody touching her.

On day six we heard from Fred who described how he was from an abusive home and found himself homeless at age 16. At age 17 he was remanded to Ashley because he had no address. He was released and then sentenced and returned to Ashley. He described how the Franklin Unit was known as the gladiator pit where violence was encouraged by the staff. He was the victim of a number of violent assaults where no youth workers intervened and he was placed in isolation as punishment because the guards did not like him. He was regularly strip-searched which made him feel belittled. He said that it was "yuck, harrowing, I hated it". He attempted to complain without any response.

1
2 In addition to the abuse that he suffered he witnessed
3 a violent rape perpetrated by one detainee on another, as
4 well as staff beatings on other detainees. As a result of
5 his experiences, he suffers from PTSD, and panic attacks.
6 He has crazy flashbacks. He said that the experience has
7 left him unable to trust anyone in a position of authority,
8 which has had implications throughout his life where he has
9 panicked, lied or done the wrong thing because he was
10 fearful of what the person would do to him.

11
12 He said in relation to Ashley:

13
14 *Tear the place down and start again. It's*
15 *systemic, it's grown in that environment.*
16

17 When we compare that evidence and other evidence
18 against what a good institution would look like, it's clear
19 that Ashley does not meet the best practice expectations or
20 outcomes for Youth Justice that I've outlined. It's not
21 just that it didn't meet them in the past, it doesn't meet
22 them today.
23

24 The community is entitled to expect that children who
25 enter Ashley are genuinely there as a matter of last
26 resort. The community is entitled to expect that children
27 at Ashley will be kept safe and not harmed. The community
28 is entitled to expect that children will leave the facility
29 in a better state than when they entered it having had
30 access to care, services, education and therapy and a
31 pathway to change the circumstances that might have led
32 them to be placed there in the first place.
33

34 But the evidence that we have heard suggests that
35 children and young people often exited Ashley further
36 harmed and traumatised, disempowered, filled with shame and
37 rage and all too often as victims of abuse.
38

39 Almost all, we were told, find themselves in Risdon
40 Prison. We heard from Ms Phillips that Ashley is
41 essentially a kindergarten for Risdon, it's like the
42 quicksand of the Legal System.
43

44 This is a system that is failing to achieve its core
45 purpose as set out in the Youth Justice Act and is creating
46 opportunities for sexual abuse to occur.
47

1 Children have been subject to invasive strip-searches
2 on a regular basis. This has been a humiliating and
3 degrading practice that occurred upon admission after
4 visits from family or excursions off property and when
5 returning from mandatory court appearances. It occurred in
6 cells, on property and out of sight of CCTV cameras. In
7 many cases there's been no suggestion of a proper basis for
8 the searches. In many cases the searches involved violence
9 and serious sexual assault.

10
11 Whether under the name of unit bound, blue program,
12 restrictive practice or isolation as defined under the
13 Youth Justice Act children have been, and continue to be,
14 subjected to being restricted to their rooms or their unit
15 with limited or no access to education, exercise or
16 engagement with other detainees for extended periods of
17 time.

18
19 There is evidence that the practice of isolation as
20 punishment has been used by staff in the recent past,
21 sometimes just because staff dislike a detainee.

22
23 You have heard evidence that the culture at Ashley
24 until very recently remained one of command and control.
25 For detainees, this was a punitive culture that regularly
26 involved violence and sexual or physical abuse both by
27 staff or from other detainees. The consequence for
28 speaking out or complaining of abuse would be retribution
29 from staff or other detainees. Many learnt that it was
30 best not to complain so that they could survive their time
31 at Ashley.

32
33 There was a limited understanding of detainees amongst
34 staff with a pervading view, it seems, that they were not
35 really children, they were bad, they were the worst of the
36 worst, they could make things up to get money, including
37 false allegations. It's clear that some of those views are
38 held by current staff.

39
40 While complaints need to be appropriately
41 investigated, it's definitely difficult to see how children
42 would feel safe or supported to make complaints at all in
43 the context of such deeply embedded devaluing and
44 disbelieving attitudes of detainees.

45
46 We recall that we heard from Professor Palmer as long
47 ago as the first week of the hearings and the expert on

1 institutional culture. He said:

2
3 *People who become guards in a detention*
4 *facility very quickly learn from their*
5 *peers what the culture of an organisation*
6 *is and it may be, for example, "never trust*
7 *a child and what they say". That might not*
8 *have been a view they held before they took*
9 *the job as a guard in a detection facility.*

10
11 This is perhaps why so many young people were at pains
12 to say to you that it wasn't just a matter of removing a
13 "few rotten apples" from Ashley, the entire barrel is
14 contaminated. Any new additions from staff would only get
15 infected as well, and that's what Max told you. He talked
16 to you about new staff who he'd be happy to see come into
17 the facility but over time he would see their behaviour
18 change. Professor White's solution to this challenge is
19 that he would "raze Ashley to the ground tomorrow".
20

21 The culture that you've heard evidence about is also
22 toxic for the staff themselves. It presents as workplace
23 bullying and harassment. We've heard evidence in earlier
24 hearings of the Commission that, where staff do not feel
25 safe in the workplace, children will not be safe. Staff
26 who held genuine and well-founded concerns about the
27 treatment of detainees were frightened or discouraged from
28 reporting them. Those who persisted, such as Ms Gardiner
29 or Alysha or the clinical psychologist, had their concerns
30 ignored or downplayed. Ms Burton said that the view in
31 relation to conducting independent SERT Reviews was that it
32 wasn't helpful to air dirty laundry in public.
33

34 Commissioners, you may find, on your consideration of
35 all the evidence, that Ashley was a closed institution, a
36 closed culture that actively prevented any scrutiny of its
37 operations. Its remote location, in addition to the
38 practices that it adopted, made visits from family and
39 support services difficult.
40

41 Investigations and reports into its operating
42 practices were hindered by a lack of information, a
43 residence to providing information, the provision of
44 misleading information and in some cases important findings
45 not being released to the public, and indeed even the
46 evidence of the current Secretary was that until the very
47 recent past Ashley was both isolated in location and had

1 isolated itself from the department.

2
3 We must acknowledge, as we have through the hearings,
4 that Ashley staff worked with some of the most
5 disadvantaged children in the state, many of whom have
6 mental health and substance abuse difficulties,
7 disabilities, have had poor education or have little or no
8 family support. It's challenging work, it requires the
9 right knowledge, skill and behaviours to be child-centred
10 and therapeutic.

11
12 Many staff are doing the best they can in very
13 difficult circumstances, but the evidence demonstrates that
14 there is a lack of qualification, a lack of training, and a
15 lack of support for staff.

16
17 Many staff have limited education. It appears that it
18 wasn't until around 2012 or 2013 that some staff obtained a
19 diploma of youth or custodial work. We've heard from
20 Mr Digney that a more direct and therapeutic approach would
21 likely require staff to have additional qualifications.

22
23 You may find, Commissioners, that the qualifications
24 and training required of the staff at Ashley was and
25 remains woefully inadequate to meet the needs of children.

26
27 From the previous reports and the evidence you have
28 heard, it's clear that staff shortages have been a chronic
29 issue for various reasons, including location, culture and
30 workplace injury. A lack of staff in itself presents a
31 risk to children.

32
33 Ms Mitchell stated that:

34
35 *When things escalate and the system's put*
36 *under stress it reverts back to the old way*
37 *of doing things.*

38
39 Inadequate supervision can mean that abuse is not
40 prevented or detected. The lack of staff has put pressure
41 on remaining staff. Some young people may now be paying
42 the price for staff frustration and dysfunction.

43
44 The lack of support and the lack of staff, coupled
45 with the intense scrutiny that workers have come under, has
46 contributed to a workforce that presently feels besieged,
47 misunderstood and unappreciated. This risks creating an

1 "us and them" mentality that can further fuel the closing
2 of ranks amongst staff and a disengagement from processes
3 that are designed to improve and change the culture of the
4 centre.

5
6 You have heard from staff who were at pains to
7 describe the difficulties of the job on a day-to-day basis
8 and the genuine fears that they held for their own safety
9 at work. We acknowledge that it's pretty easy for us who
10 do not do that job on a day-to-day basis to have views
11 about what should be done at Ashley. We make those views
12 and those assessments removed from the grit and the grind
13 of what is undeniably a very difficult and stressful job,
14 but it would be to do a disservice to both detainees and
15 the staff if we do not frankly consider the improvements
16 that are necessary to the system, culture and practices
17 there, improvements which will all protect children from
18 harm.

19
20 We heard from Professor White that Ashley looks like a
21 prison, it smells like a prison, it feels like a prison.
22 As we've heard many times, the location of Ashley is
23 remote. This remoteness has prevented the recruitment of
24 qualified and professional staff, necessary support
25 services have not been available, family connections have
26 been lost, there's no connection to community.

27
28 There was certainly positive comments made by a number
29 of witnesses about the school at Ashley, but the right to
30 education has been limited because of practices either
31 under the Behaviour Management System or the use of
32 isolation practices or more recently through staff
33 shortage-induced restricted practices.

34
35 It's also difficult to see how education can be
36 delivered effectively to young people on remand who might
37 exit and enter the system as part of a constant churn. And
38 again, it's worth remembering of the 11 children there
39 right now or yesterday, 10 of them are on remand.

40
41 It appears on the evidence that there is presently
42 little or insufficient thought given to exit plans.
43 Children can be released with no accommodation, no
44 continuation of services, no education, only a bag of
45 toiletries as was Charlotte's experience. They leave only
46 to breach bail and re-offend and return.

47

1 The heightened risk of child sexual abuse associated
2 with closed institutions when those in power have total
3 control over the lives of those within the institution,
4 what they eat, their privileges and punishments, their
5 contact with the outside world, has long been recognised.
6 It creates a critical role for those concerned with their
7 oversight. In Tasmania this is, to different and varying
8 degrees, the role of the Custodial Inspector who is also
9 the Ombudsman and Health Complaints Commissioner and the
10 OPCAT monitor and the Commissioner for Children and Young
11 People.

12
13 We heard this week that the respective offices of the
14 Custodial Inspector, the Ombudsman and the Commissioner for
15 Children and Young People are not fully resourced nor fully
16 empowered to perform a thorough and active monitoring
17 function. They predominantly rely on children and young
18 people themselves raising concerns with them. They often
19 rely on anecdotal reports from staff and assurances from
20 management combined with their own observations from site
21 visits.

22
23 In their evidence, the Custodial Inspector, Ombudsman
24 and the Commissioner accepted that the onus to raise
25 systemic failures in child safety should not fall to the
26 detainees who are the most disempowered and vulnerable.
27 They also accepted that there are unique barriers that will
28 likely deter young people in Ashley from speaking up.

29
30 We heard from Mr Connock of his regret of a complaint
31 that did make its way to the Ombudsman being forwarded back
32 to Ashley Management to manage without any independent
33 scrutiny or management from his office. The complainant
34 whose complaint was sent back went on to be sexually abused
35 in Ashley again and again and she never again made a
36 complaint.

37
38 While both Mr Connock and Ms McLean cited some
39 measures that in the recent past have made them more
40 accessible to young people, including direct phone access,
41 promotional materials explaining their role, the question
42 of how to create a culture where young people can feel that
43 they can speak up and have confidence in the integrity of
44 complaint processes remains a challenge to be addressed.

45
46 We heard that at times there have been deficiencies in
47 the police's notifications processes to external agencies,

1 including the department and the Registrar for Working with
2 Vulnerable People, and there have been challenges on
3 information sharing that can have an impact on child
4 safety. Acting Deputy Commissioner Higgins said that
5 police members at times may have had a tendency to view
6 allegations made by detainees as false. While he didn't
7 think this was a common practice, he acknowledged that
8 there is work to be done to address unconscious bias in
9 this area.

10
11 Given the evidence of the victim-survivors who have
12 come forward to the Commission, the large number of claims
13 of abuse under the National Redress Scheme, state abuse
14 claims and civil litigation against the State, it's our
15 submission to you, Commissioners, that you are able to find
16 that child sexual abuse has occurred at Ashley Youth
17 Detention Centre since 2000.

18
19 You may also consider a finding that the State was
20 aware of these allegations of abuse a number of years ago
21 and did not, as a State, take sufficient action to satisfy
22 itself that children at Ashley were safe from the risk of
23 child sexual abuse from alleged perpetrators who remained
24 in the State Service and working at Ashley.

25
26 While the government received allegations in relation
27 to Ashley employees through the Abuse in State Care program
28 from 2003 to 2013, it can now be seen that a number of
29 those employees continued to work at Ashley with access to
30 children and important records that might have helped keep
31 children safe were, for reasons that you will consider as
32 you deliberate, not made available and not used to keep
33 children safe.

34
35 Once those records did start to get used and
36 historical allegations started to be reviewed in 2020
37 Mr Graham, the Registrar for Working with Vulnerable
38 People, took the view that the leadership of the department
39 didn't see it for the crisis that it was. His view was
40 that there were multiple grave allegations against current
41 staff that got a "business as usual" response.

42
43 You've heard evidence that the state did work through
44 a process of dealing with the implications of these very
45 serious and multiple allegations once they reviewed the
46 allegations and took some action. However, it may be open
47 to you that there was a lack of sufficient urgency in the

1 department's response to the number of allegations that it
2 came to be aware of both through a review of the Abuse in
3 Care records and through new claims that were made.
4

5 Ms Allen has provided evidence of the efforts that
6 have been undertaken to remedy problems that were
7 identified. Ms Clarke and Mr Pervan have given evidence
8 that in their view the department did act with urgency. It
9 remains an open question for your consideration whether
10 those efforts were sufficient.
11

12 We note that the resources for the effort of reviewing
13 records and taking action came from inside and at the
14 expense of the existing budget envelope within the
15 Department of Communities.
16

17 Mr Pervan did accept in his evidence that, having
18 regard to the cases put to him and based on the information
19 available to the department from the various schemes, there
20 was systemic failures in the way in which information known
21 to the State through various processes were used to keep
22 children safe.
23

24 There were lengthy delays in responding to allegations
25 that were raised against current employees. For example,
26 we heard about Lester, about whom a child sexual abuse
27 allegation was raised in January 2020. It was not
28 until November of that year that he was stood down and an
29 investigation process was commenced.
30

31 The department's position is that Lester was in a
32 policy role during this intervening period, but the
33 evidence is that he still had contact with children and
34 conducted at least one strip-search during that time.
35

36 We heard evidence from the Ashley Centre Manager,
37 Mr Watson, that he raised concerns about employees like
38 Lester remaining on site, including from Ms Honan who also
39 said that she had expressed similar concerns.
40

41 We've heard evidence that the government's application
42 of the ED5 process has meant that allegations raised
43 against Ashley staff have not been treated with a child
44 safety lens. They have not placed children and their
45 rights and needs at the centre of decision-making.
46

47 You've heard evidence that harmful sexual behaviours

1 displayed by detainees towards other detainees have been
2 referred to as "horsing around" or "adolescent behaviour"
3 with the concerns of highly skilled practitioners
4 disregarded, and the seriousness of behaviours minimised.
5

6 There's an open question, Commissioners, about whether
7 these failings are not just systemic but also the result of
8 individual decisions and actions which should be
9 criticised. That is a genuine inquiry. During the course
10 of these hearings new information has become available to
11 the Commission and a range of factual matters have been
12 raised by some witnesses which are contested by other
13 witnesses, including Mr Watson and Ms Honan.
14

15 The Commission will continue to liaise with relevant
16 parties to invite them to provide additional relevant
17 information and will consider their submissions. The
18 Commission will need to consider carefully the totality of
19 the evidence, including evidence which may yet be received,
20 before coming to any view about any individual's role.
21

22 However, moving then to consider the question of
23 what's going to replace Ashley. It's open to the
24 Commission to find that there has thus far been a lack of
25 progress in planning for the progress of Ashley, both in
26 terms of transition planning and building the new
27 facilities.
28

29 Without wanting to unfairly diminish the challenge, if
30 remanded children were taken out of the equations as we've
31 heard on the evidence they should, they shouldn't be
32 remanded, the state is essentially tasked with safely
33 accommodating what will always be a handful of children.
34 But as we speak, the current state of operations at Ashley
35 sees children sometimes locked in their room for 23 hours a
36 day, essentially warehoused, with one hour to do what they
37 wish, usually to call home instead of school. They might
38 talk to the Commissioner and her advocate behind locked
39 doors, they have limited access to legal advice.
40

41 Mr Morrissey stated that isolation, which is what the
42 current restrictive practices are, is tantamount to
43 torture, but there appears to be a lack of urgency from the
44 government to change the situation for these children,
45 nearly all of whom are on remand.
46

47 It's likely that between now and the closure of

1 Ashley, a date which it now seems is actually yet to be
2 fixed and not at all certain, many young people will come
3 and go in and out of the doors of Ashley and be subjected
4 to the same treatment in spite of the efforts of current
5 staff to keep the centre operating.
6

7 Of course we must acknowledge that the issue of what
8 is the best model to replace Ashley is a complex question,
9 but there are existing models that Tasmania can consider
10 including the one operating in the ACT which you heard from
11 Ms Grace about today. There's an opportunity for Tasmania
12 to look at these models and create the one that best suits
13 Tasmania. Indeed, the small numbers of people who would
14 require such a facility mean that Tasmania is uniquely
15 poised to implement what Professor White called "a
16 Tasmanian model", a bespoke system that matches the
17 specific needs of Tasmania's children and young people and,
18 rather than isolating and segregating children, they can be
19 in home-like facilities with professional support and
20 mentors.
21

22 This echoes what we heard from victim-survivor Sam
23 Leishman during our Education hearings when he said:
24

25 *Why can't we look at Tasmania as being a*
26 *small isolated state and that's actually*
27 *our advantage. We are small, we can set*
28 *the standards and we can be the one that*
29 *says, this is the benchmark that everyone*
30 *else has to meet. There's no reason why we*
31 *can't do things better than the rest of the*
32 *country.*
33

34 But to see significant change there needs to be strong
35 leadership and an ongoing commitment to see reforms
36 implemented and monitored until they are embedded.
37

38 We heard from Ms Mitchell that:
39

40 *Once we know what we want to happen, the*
41 *implementation window is a five to*
42 *seven year window. It's not planning to do*
43 *it, but actual doing of it; the*
44 *implementation of it as a long-term*
45 *proposition.*
46

47 The government has announced consultation on the Youth

1 Justice Blueprint Discussion Paper which will set the
2 strategic direction for the Justice System over the next
3 10 years, but it's unclear why action on Ashley has to be
4 dependent on that wider Youth Justice reform. If it's
5 accepted that there will always be some role for a
6 detention centre, the closing of Ashley and actively
7 planning for an alternative must be considered now.

8
9 As we've said in opening, nothing we have said and
10 heard this week will have been new to the government. The
11 government already knew all of the issues that are being
12 raised. The government has had the benefit of 20 years of
13 reports on Ashley, each report making recommendations and
14 findings that are tragically similar cross the decades and
15 could still be found by you now; findings that Ashley is
16 not fit for purpose.

17
18 The government could implement recommendations that
19 are currently outstanding in those reports. A failure to
20 act now and implement a transition plan before Ashley's
21 closure will see children continue to be subject to
22 inhumane and degrading conditions and continue to be at
23 risk of child sexual abuse.

24
25 If the Commission pleases.

26
27 PRESIDENT NEAVE: Thank you very much for your submission,
28 Ms Ellyard.

29
30 Before we close: this has been a very difficult period
31 in our hearings I think. I know that a number of the
32 people who are here present today have got a direct
33 interest, either as survivors of child sexual abuse or as
34 people who have expressed their views and tried to do
35 something about the matters that have been brought to our
36 attention.

37
38 I just want to remind people that there is support
39 available, some support available through the Commission
40 through our Community Engagement Team. So, if anybody
41 needs to - anyone falling into those categories needs to
42 talk to the Community Engagement Team, people will be
43 available to do that.

44
45 Now, I'm sorry, I'm not sure that there will be anyone
46 available over the weekend, but certainly next week if
47 anyone needs to contact our Community Engagement Team and

1 to seek support, that will be available. On the website we
2 also refer to, I think, other sources of support.

3
4 So, thank you very much everyone who's present and I
5 do hope that people who need assistance or help will avail
6 themselves of it.

7
8 Thank you very much, Ms Ellyard, and also Ms Rhodes
9 and other counsel who are not present, and also counsel for
10 the State and other counsel, and we will now adjourn.

11
12 **AT 3.06PM THE COMMISSION WAS ADJOURNED TO**
13 **WEDNESDAY, 7 SEPTEMBER 2022 AT 10.00AM**