

---

**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 22 August 2022 at 10.20am**

**(Day 27)**

1 PRESIDENT NEAVE: Before we start, I'd just like to remind  
2 everybody present that there are some orders in place,  
3 restricted publication orders, and the orders are actually  
4 posted on the door of this hearing room. If anyone has any  
5 questions, any member of the media who's here has any  
6 questions or issues they want to raise about what they can  
7 and can't say, then they can talk to our media officer.  
8

9 And I think we have an appearance, don't we, to  
10 announce? Yes.

11  
12 MR P ZEEMAN: Yes, my apologies, Zeeman, I appear for  
13 Ms Gardiner, the first witness this morning.

14  
15 MS NORTON: And I just note, there has been a switch in  
16 witnesses, we'll be hearing from Erin after Ms Gardiner's  
17 evidence.

18  
19 PRESIDENT NEAVE: Thank you.

20  
21 MS NORTON: If the witness can be sworn in, please.

22  
23 <MADELEINE CLAIRE GARDINER, sworn: [10.21am]

24  
25 <EXAMINATION BY MS NORTON:

26  
27 MS NORTON: Q. Can I ask you to state for the  
28 transcript your full name, professional address and  
29 occupation, please?

30 A. Madeleine Claire Gardiner, and professional address is  
31 52 Franklin Street, Launceston. My occupation, I'm a  
32 Registered Nurse and also a social worker.

33  
34 Q. Thank you. You've provided a statement to the  
35 Commission in response to a request for a statement; that  
36 statement is 54 pages and it has 26 attachments. Are there  
37 any corrections or additions you'd like to make to that  
38 statement?

39 A. Yeah, there's one correction or addition I'd like to  
40 make. I forgot to mention that there was a staff, a new  
41 position I started to supervise in my role as manager. I  
42 didn't - that position came on board partway through my  
43 management and it was the clinical practice consultant  
44 position, so I recruited to that position as well and then  
45 supervised that in its infancy.

46  
47 Q. And so, you would wish to add reference to that

1 particular position to your answer to Question 4 in the  
2 statement?

3 A. Yes.

4

5 Q. Thank you. Subject to that addition, is the statement  
6 otherwise true and correct to the best of your knowledge  
7 and belief?

8 A. Yes.

9

10 Q. Thank you. You outline in your statement your  
11 professional background and you have a range of  
12 qualifications, notably dual qualifications as a social  
13 worker and a nurse; is that right?

14 A. That's correct.

15

16 Q. And you've got Masters degrees in both of those  
17 disciplines?

18 A. That's correct.

19

20 Q. You commenced work at the Ashley Youth Detention  
21 Centre in July 2017 in a contract role; is that correct?

22 A. That's correct.

23

24 Q. And then you were employed in a permanent role as a  
25 Manager Professional Services and Policy from March 2018;  
26 is that correct?

27 A. Yes.

28

29 Q. What was your role or the nature of your role in that  
30 manager position?

31 A. So, I worked .7, which is seven days a fortnight in  
32 that role and the other hours of that role were shared with  
33 another manager who was also titled "Professional Services  
34 Manager".

35

36 Q. Yes.

37 A. And so, we had a division of work duties; there was a  
38 division of work duties and I oversaw the case management  
39 work, the conferencing, pretty much facilitated a lot of  
40 the meetings that were involved in that, and a key part of  
41 it was providing consultation on complex casework as well  
42 as things like planning for the young people when they exit  
43 the facility, overseeing their assessment when they enter,  
44 so I had staff that were doing that work, so the manager  
45 for that casework that goes with it.

46

47 Q. Would it be accurate, you referred to the fact that

1 you were job sharing the role; would it be fair to say  
2 the .7 of the role that you occupied was really to do with  
3 oversight on case management, conferencing and program  
4 delivery and the person you job shared with was more  
5 responsible for policy and procedure work; is that a fair  
6 division?

7 A. Yes, that's right.

8  
9 Q. As I understand it, the manager of PS&P also chaired  
10 the Multi-Disciplinary Team. Was it you or your colleague,  
11 or both of you from time to time who held that chair role  
12 in the MDT?

13 A. Usually it was me; I mainly did it. If I wasn't  
14 present for the day the other manager would chair the  
15 meeting.

16  
17 Q. And you reported in your role to the centre manager?

18 A. That's correct.

19  
20 Q. And initially - there were two people in that role  
21 during your time; for the latter part it was Mr Patrick  
22 Ryan; is that correct?

23 A. My memory was that there was mainly Mr Ryan in the  
24 position.

25  
26 Q. Okay. I'd like to ask you some questions about work  
27 culture, workplace culture at Ashley Youth Detention  
28 Centre. You say in your statement that for the first six  
29 to eight months that you were working there you thought  
30 that it was a positive culture but it declined over time.  
31 Are you able to outline for the Commissioners what that  
32 decline looked like and any insight you have into why it  
33 occurred?

34 A. I felt like when I started there, there was a change  
35 manager working on developing a therapeutic approach and a  
36 change direction in the centre, and he ran a lot of  
37 collaborative meetings with some professional experts and  
38 involved a lot of staff in the centre in those meetings and  
39 I felt like there was an energy and an appetite for making  
40 some significant improvements in the centre.

41  
42 He also, in that role, brought in a lot of  
43 contemporary theory to the practice of how staff should be  
44 working, and I felt like the staff were really quite  
45 receptive to that. He ran some meetings and some  
46 professional development days that was across teams; like,  
47 across the Health Team, the Education staff, my team, the

1 Professional Services staff, and the Operational Team, and  
2 some of that was some quite good relationship building  
3 exercises to develop relationships across the teams.  
4

5 Q. And that was particularly important in the context of  
6 Ashley, wasn't it, that there be collaboration across those  
7 teams?

8 A. Yes.  
9

10 Q. You say in your statement that that change manager  
11 role was only funded until, I think, was it mid-2018?

12 A. Yes.  
13

14 Q. And then the role ceased, and you subsequently noticed  
15 a decline in culture, and in your statement you also say  
16 that there was a decline in your relationship with senior  
17 management around the same time. I'm going to ask you  
18 about that but, before I do, can I ask you to share any  
19 observations you have with the Commissioners of the senior  
20 management team and how the members of that team worked  
21 together, the relationships they had?

22 A. So, this is the relationships of the senior management  
23 group team?  
24

25 Q. Yes.

26 A. My observations around that were probably that, while  
27 those initial exercises of relationship building helped  
28 when the change manager was there, after that change  
29 position stopped there was one meeting a week that we had  
30 as a group; it was an information sharing meeting, I  
31 wouldn't say there was any, like, relationship building or  
32 relationship development as part of that meeting. People  
33 pretty - it was a bit of an update, so once a week there  
34 would be a bit of an update on how things were working.  
35

36 As far as the relationship of senior management ...  
37

38 Q. Can I ask you the question this way: did you observe  
39 members of that management team socialising outside of  
40 work, did they have relationships beyond the professional  
41 roles at the centre?

42 A. The senior - not all the senior management group, it  
43 depends who we refer to as the senior management group. If  
44 we're talking about the operations manager, they didn't  
45 socialise together, or not that I know of, but there were  
46 some other managers that did socialise together outside of  
47 the workplace.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. And, were you part of that group?

A. I was invited but I didn't socialise unless it was an all staff socialising event.

Q. And, did you have a rationale for that decision?

A. Yes, pretty much that I think I would socialise when all staff and it's an open invitation to all staff, because that would be seen as a social opportunity to develop relationships amongst all staff, but I'm not somebody that socialises just for the sake of socialising with people at work; I would prefer to do the work and then, yeah, just to have general social activities involving all staff.

Q. Did you have any concerns that socialising with members of the management team outside of work might somehow compromise your ability to do your job at all?

A. That's always a concern for me as a professional.

Q. Can you explain the nature of that concern to the Commissioners?

A. Yeah, I probably feel like, if you're socialising on a Friday night together, it could compromise that you - how you may perform in your professional role to have robust conversations, and I'd like to keep my work and personal life separate.

Q. Thank you. You say in your statement that it was towards the end of your time at the centre and in 2019 that you started to feel psychologically unsafe around the centre manager, Mr Ryan; we'll probably come to some examples of that in due course, but is there anything you would like to say to the Commissioners by way of elaboration in terms of how you felt unsafe?

A. I noticed some behaviours that I felt were a bit like red flags for feeling that I was not sure where I - whether I was safe. I noticed that I - there were meetings held; we share calendars and I noticed some meetings were set up that I wasn't included in, so I started to wonder what was going on.

And then there were a couple of instances, I could give an example, if you'd like?

Q. Sure.

A. I was actually helping filling in for the program, my program coordinator, because he was off sick or something

1 like that, so I was working with some young people and I  
2 was approached by Mr Ryan and another senior manager in the  
3 centre to go to his office, and I went to his office and  
4 that's where he told me that I was never to cancel meetings  
5 that were scheduled with him again, and not by email, and I  
6 just found the concept of a female being approached by two  
7 quite big men in a detention centre to be told to go and  
8 meet with them quite - a little bit threatening and  
9 imposing, and I also felt like that the requirement that  
10 I'm never to reschedule a meeting with my manager quite  
11 unjust and unfair, and I started to sense a use of power.  
12

13 Q. You made mention then to feeling somewhat threatened  
14 by being approached by two large men at the centre. The  
15 Commission has heard evidence in previous weeks from  
16 Professor Salter that all boys' institutions can often  
17 present with cultures that are hyper-masculine and at times  
18 misogynistic, and that those sorts of environments can  
19 create a heightened risk for child sexual abuse.  
20

21 Now, I appreciate that when you were working at the  
22 centre it wasn't a boys only institution but it had its  
23 history as one and, as I understand it, the majority of  
24 detainees were male. Did you experience a hyper-masculine  
25 or misogynistic culture at all while you were at work?

26 A. I started to observe that more towards the end of my  
27 time there. I suppose I wasn't aware of it until I felt  
28 threatened by it and felt like I couldn't challenge it.  
29

30 Q. I anticipate that Mr Ryan, who is going to give  
31 evidence tomorrow, might give evidence that there had been  
32 some complaints made about you, that it was your way or the  
33 highway, that that was how you approached decision-making  
34 in the CST and the MDT and he refers also to some conflict  
35 with the Nurse Unit Manager. I'd like to invite you to  
36 respond to that evidence?

37 A. Mr Ryan never had a conversation with me about that  
38 being my management style; I would have expected, if he  
39 experienced that in me and he was my manager, that he would  
40 have had a conversation with me about that and given me  
41 some feedback so, if I was really coming across like that  
42 with staff, that I would have an opportunity to perhaps  
43 change, and that never happened and --  
44

45 Q. Sorry, was that news to you, what I've just said to  
46 you, that was not ever raised with you during your  
47 employment?

1 A. That was not raised with me, no.

2

3 Q. Is it consistent with any of your interactions with  
4 your colleagues, your NUM colleagues or other colleagues on  
5 the CST and the MDT?

6 A. No, there was no conflict between myself and the NUM.

7

8 Q. I'd like to ask you some questions next about the  
9 Operations Team. What were your observations about the  
10 relationship between Operations and your Professional  
11 Services Team over time? I think you use the word  
12 "conflictual" in your statement. Would you like to  
13 elaborate for the Commissioners on the nature of the  
14 conflict?

15 A. M'hmm. I would say there was some conflict, and to  
16 some degree I would have expected the conflict to be  
17 normal, normal conflict that arises in complex case  
18 management and practice because that's the nature of the  
19 work. There was definitely conflict that arose because -  
20 that came from - well, the team in Professional Services  
21 came very much from a theory and evidence base and I feel  
22 like a lot of the staff working in Operations came from a  
23 practice of, this is what we've always done and this is  
24 what we do to keep - operate the centre and to keep the  
25 centre safe, and the staffing and Professional Services  
26 Team would have been presenting views that were about what  
27 was in the best interests of the children, so at times that  
28 would be conflictive, and I would have expected that to be  
29 normal and then we would have used that as an opportunity  
30 to work out how, how do we work through that.

31

32 Q. And did that play out? Was the relationship  
33 collaborative or did the interests of management of the  
34 centre and Operations tend to rule the day?

35 A. At times it could be collaborative, and I saw some  
36 very good collaborative work. I saw some staff really  
37 wanting to embrace information and ideas from the  
38 Professional Services Team and other staff dismiss that  
39 completely.

40

41 Q. Now again, I anticipate Mr Ryan will give evidence  
42 that you didn't give sufficient credit to Operations;  
43 that's certainly inconsistent with your answer to my  
44 previous question: do you have a response you'd like to  
45 give about whether that's a fair characterisation of your  
46 approach?

47 A. No, I don't think that's fair at all.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. I'd like to hand up to you a list of pseudonyms. I'd like to ask you some questions about a young person who we'll refer to as "Margaret". You see Margaret listed there and you know who I'm talking about?

A. Yes.

Q. Margaret was a particularly vulnerable young person and she'd been known to Child Services since she was an infant, and I think that's information you now have; you may not have been aware of the extent of her involvement with Child Safety Services at the time you were at the Centre, but you were aware she was a vulnerable young person?

A. Yes.

Q. In June 2019 there was a sexual incident involving Margaret and two male residents. Your statement refers to a concern you had at the time that that incident wasn't properly documented in MDT minutes. I think you weren't at the relevant meeting; is that correct?

A. That's correct.

Q. You looked at the minutes afterwards. And it came to your attention because a member of your team raised concerns that case management - that is, part of the Professional Services Team - hadn't been involved in the decision to place Margaret in the same unit as the two residents that she had the sexual incident with. Do you recall your employee raising that concern with you?

A. Yes, I was made aware of the concern on the Tuesday the following week after the incident by someone in my team, and they had sent an email to me on the Friday to me about that, but I wasn't working on the Friday, and I became aware of the incident, that it had occurred. I was aware the week before that the two male residents had been put in the same unit with a female, but I'd been advised that it was supervised and that it was quite a successful management strategy, they just did it for a short-term time, so I'd been advised that it happened but that it had been quite successful and there was no problem.

Q. So that was your understanding, and I think one of your attachments to your statement, and it's attachment 23, is that the email that came to you subsequently from someone in your team who raised concerns that case management hadn't been consulted in the decision to put the

1 three residents together and that she would not have agreed  
2 because of Margaret's mental health and trauma history. Do  
3 you recall that concern?

4 A. Yes.

5

6 Q. Is that an example of, or potentially an example of  
7 your team being excluded by Operations or not being  
8 consulted by Operations when decision-making?

9 A. Yes.

10

11 Q. You said before that your understanding the previous  
12 week was that it was a well supervised arrangement and that  
13 it was working well. Does the fact that this sexual  
14 incident was allowed to happen cause you to have concerns,  
15 or did it at the time cause you to have concerns about the  
16 appropriateness of the supervision?

17 A. Significantly, yes.

18

19 Q. Would you like to explain that to the Commissioners?

20 A. Well, I actually wondered how an incident like that  
21 could have happened, if there are youth workers in the unit  
22 and able to supervise young people all the time, I just  
23 wonder what level of supervision was being provided to the  
24 young people in the unit; it sounds inadequate.

25

26 Q. Another matter that you're --

27

28 COMMISSIONER BROMFIELD: Sorry, Ms Norton.

29

30 MS NORTON: Yes.

31

32 COMMISSIONER BROMFIELD: Q. In that context,  
33 Ms Gardiner, would you have expected it to be what was  
34 termed in the centre, I believe, very close supervision: if  
35 you were going to place a teenage girl into a unit with two  
36 teenage boys, would you expect that it would be very close  
37 supervision at all times?

38 A. Absolutely.

39

40 COMMISSIONER BROMFIELD: Thank you.

41

42 MS NORTON: Q. I just want to read you an email, it's  
43 one of the attachments to your statement, it's  
44 Attachment 24 if you want to go to it. It's an email from  
45 Mr Ryan that you were copied in on. One of the other  
46 concerns that your team member raised was that she thought  
47 this matter should be reported to Child Safety Services and

1 I think also Children, Youth and Family. You raised that,  
2 I think, with Mr Ryan. Then there's an email that you've  
3 been copied in on that says:

4  
5 *The matter has been escalated to directors.*  
6 *I have had further conversations. No other*  
7 *member of staff is required to action any*  
8 *correspondence. I also take the*  
9 *opportunity to thank you in advance for*  
10 *your support of the centre and Margaret in*  
11 *challenging any unhealthy discussion or*  
12 *discussion in unnecessary forums.*

13  
14 I'd just be interested to know what you make of that  
15 in the context where you were suggesting that a  
16 notification be made to Child Safety Services?

17 A. I interpreted that as a shutting down of any further  
18 communication by anyone else in the centre with anybody  
19 outside the centre as well as asking us to sort of shut  
20 down any conversation within the centre about it if it's  
21 unhealthy; I interpret that Mr Ryan would take it from  
22 here.

23  
24 Q. Thank you. You also refer in your statement to some  
25 decision-making that seemed to you to lack a proper  
26 rationale, and it's page 39 of your statement if you want  
27 to orient yourself, but it's decision-making in relation to  
28 visitation rights of two Indigenous detainees. I'll just  
29 remind you, the first involved a resident being denied a  
30 visit by their brother with no rationale or policy  
31 justification, that comes from your statement.

32  
33 And the second, if I might get you to speak to this in  
34 a bit more detail, involved an Indigenous detainee being  
35 denied a visit - well, a visit had been approved, as I  
36 understand it, that a member of the Tasmania Aboriginal  
37 Centre could come to the centre to sit with him while he  
38 viewed footage from his father's funeral and ultimately  
39 that didn't go ahead as scheduled. Could you explain that  
40 incident to the Commissioners?

41 A. The incident of?

42  
43 Q. The second incident, yes.

44 A. So, the staff in my team had organised for someone  
45 from the Tasmanian Aboriginal Corporation to sit with a  
46 young person whose father had died recently, a young  
47 Aboriginal man, and he was not allowed to attend the

1 funeral in person because of his legal - relevant approval  
2 wasn't given for him to attend it, and there was organised  
3 for a youth mentor from the TAC to come out who he had a  
4 close relationship with to come and - he was going to come  
5 out and bring the video of the funeral out for him to  
6 watch.

7  
8 Q. Is that something that you as a professional regarded  
9 as therapeutically important for this particular young  
10 person having lost his father?

11 A. Absolutely, yes.

12  
13 PRESIDENT NEAVE: Q. Could I just ask another question  
14 about that? So, the young Indigenous person was prevented  
15 from going to his father's funeral. Who made that  
16 decision?

17 A. The centre manager.

18  
19 Q. The centre manager said he shouldn't go to his  
20 father's funeral?

21 A. He didn't approve him attending the funeral.

22  
23 Q. Have you any awareness as to why that might have  
24 happened?

25 A. No, I wasn't involved in that decision.

26  
27 PRESIDENT NEAVE: Thank you.

28  
29 MS NORTON: Q. And why was it that the visit from the  
30 community member, having previously been approved, was then  
31 prevented from occurring on the day that it was scheduled?

32 A. Well, I wasn't actually made aware that it was going  
33 to be prevented, I was told after the event by someone in  
34 my team, by the case manager who'd organised it. Why was  
35 it prevented? The operation coordinator at the time  
36 determined --

37  
38 Q. That's a person who we're referring to as "Maude",  
39 that's the pseudonym. So, Maude?

40 A. Maude determined, made the determination that they  
41 couldn't facilitate the visit. There always needs to be a  
42 staff member supervisor visit, and they determined that  
43 there wasn't enough staff on the ground to supervise the  
44 visit. And my understanding was that the person in my team  
45 had already alerted her to the fact that they could  
46 supervise the visit, so that's someone who's not  
47 operational would supervise it. It still got cancelled and

1 it got cancelled with the permission of the centre manager.

2

3 Q. So, no consultation?

4 A. No consultation.

5

6 Q. No, but the cancellation was approved by the centre  
7 manager?

8 A. Yes.

9

10 Q. Listening to that account, it sounds like a  
11 particularly cruel decision; did you have that concern at  
12 the time?

13 A. I understood the operations coordinator having to make  
14 a difficult decision based on how they staff their centre.  
15 I thought it was not child-focused, the decision  
16 whatsoever; I thought as a centre we would make every  
17 effort to make sure a young person would be able to sit  
18 with somebody and view their father's funeral. I thought  
19 it was very insensitive, yeah.

20

21 COMMISSIONER BROMFIELD: Q. Am I right in recalling from  
22 your statement that the visit was cancelled when the person  
23 from the TAC had arrived at the centre?

24 A. Yes.

25

26 Q. So, for both that person and for the young person,  
27 they were mentally prepared for that, the viewing of the  
28 funeral happening at that point in time?

29 A. That's what I was advised by the staff member in my  
30 team, yes.

31

32 COMMISSIONER BROMFIELD: Thank you.

33

34 MS NORTON: Q. Appreciating that your knowledge about  
35 these conversations is based on what your team member told  
36 you, but you mentioned before that your team was available  
37 to provide some back-up supervision given that Operations  
38 were stretched; do you recall whether that offer was  
39 properly considered or whether there was a good rationale  
40 provided for why that wouldn't be adequate?

41 A. There was no rationale, and I don't remember hearing  
42 that it was ever considered.

43

44 Q. They're two difficult and isolated examples of what  
45 seemed to be unsupported decisions in relation to  
46 visitation rights for Indigenous detainees. Bearing that  
47 in mind, are they just isolated incidents or did you have

1 concerns about there being a broader pattern of racism  
2 towards Indigenous detainees at the centre?

3 A. I can't really comment on that because I didn't see  
4 enough to know.

5  
6 Q. Sure. I'd like to move next to the behavioural  
7 management at the centre. Can you just address the  
8 Commissioners, I'll invite you to address the Commissioners  
9 on why therapeutic practices are particularly important,  
10 and trauma-informed care, are particularly important at a  
11 place like Ashley?

12 A. I suppose understanding the children that we're  
13 working with is the key part of the practice and, given  
14 that a lot of the children in the centre have experienced  
15 often a background of fairly significant trauma, we would  
16 then see trauma behaviour from people who have experienced  
17 trauma, which is often a higher level of escalation, that  
18 triggering of fight or flight responses, so understanding  
19 what is influencing a young person's behaviour is key  
20 before we then respond to the behaviour, and probably even  
21 the conversation about behaviour management doesn't really  
22 reflect a trauma-informed approach because, if we're  
23 understanding what's happening for a young person, it's how  
24 we respond that matters rather than how we manage.

25  
26 PRESIDENT NEAVE: Q. Can I just intervene. Just from  
27 the point of view of members of the public who might be  
28 viewing this on the live stream or might be present, you  
29 said "a high level of escalation". Could you put that into  
30 sort of language that a person who's not familiar with that  
31 term would understand?

32 A. Yes. So, we know from the areas and evidence of how  
33 trauma affects the brain, people who are affected by trauma  
34 tend to operate from areas of the brain that are in the  
35 lower levels of brain that are geared towards fight or  
36 flight responses because it's about trying to keep  
37 themselves safe because, when they've experienced trauma  
38 they've had to learn ways to keep themselves safe, so  
39 that's operating often from what's called the amygdala  
40 which is a part of the brain which fires quite quickly when  
41 people feel threatened, and so you'll see fight or flight  
42 responses.

43  
44 Q. So, a detainee who has been exposed to trauma as a  
45 child, when put in a centre like this, might be verbally or  
46 physically violent in certain situations where they feel  
47 threatened; is that an easy --

1 A. Absolutely.

2

3 Q. Thank you, and the only way to deal with that is that  
4 a, sort of, an equally violent response is not an effective  
5 way of dealing with that?

6 A. That's right.

7

8 PRESIDENT NEAVE: Thank you.

9

10 MS NORTON: Q. Just carrying on from what the President  
11 said there, the exchange you've just had, is it also the  
12 case that because there's this escalation of work, this  
13 fight or flight response the behaviour which might  
14 initially be seen as quite aggressive is actually really  
15 defensive?

16 A. Yes.

17

18 Q. Thank you. You've spoken to the importance of  
19 therapeutic practices at a place like Ashley, and I want to  
20 be careful - I know you've already acknowledged that there  
21 were members of the Operations Team who did bring a  
22 sensitive and trauma-informed approach to their work; was  
23 that the case across the Operations Team or did you have  
24 concerns that these principles of trauma-informed responses  
25 and therapeutic practices weren't well understood by some  
26 in the Operations Team?

27 A. Yes, I would agree with that.

28

29 Q. Would it be fair to say that, instead, the approach of  
30 people in that category was more a command and control type  
31 response to behaviour management?

32 A. Yes.

33

34 Q. While you were at the centre there was a behaviour  
35 development system that was a policy that guided responses  
36 to problematic behaviour, and you say in your statement  
37 that you didn't think that was an appropriate response or  
38 an appropriate system for this particular cohort of  
39 detainees; can you explain why you held that view?

40 A. Well, it's based on behaviour modification and the  
41 principles of rewarding behaviour that we like to see and  
42 consequences for behaviour that we wouldn't want to see or  
43 wouldn't want to encourage. I don't think it's nuanced  
44 enough to work with the complexities of the young people  
45 that are in the centre. It's not trauma-informed, so it  
46 doesn't take into account the effects of trauma on the  
47 brain.

1  
2 It actually had in the principles at the time that  
3 it's based on, that all young people have choice and, if  
4 young people are operating from their amygdala and they've  
5 got fight or flight responses or trauma responses, in that  
6 moment they don't have a choice in how they respond. So,  
7 what we'll see is that they're rewarding behaviour that we  
8 want to see, but actually having consequences for behaviour  
9 that could be a trauma response, and the consequences are  
10 negative consequences so, removal of privileges, and  
11 removal of privileges or that reward and consequence is  
12 quite effective as a behaviour modification for children  
13 who are able to engage their cortex or higher level brain  
14 areas to make decisions, so it works in some, in really  
15 well-regulated children, but it doesn't work for  
16 unregulated young people.

17  
18 Q. Is another way of putting that, picking up on the  
19 President's point, putting it into layman's terms, it was a  
20 program that pre-supposed that the children or young people  
21 at the centre were in control of their behaviour?

22 A. Absolutely.

23  
24 Q. But when they were acting out in problematic ways,  
25 they probably weren't in control of their behaviour and  
26 unable to make decisions for that reason?

27 A. Yes.

28  
29 Q. What would have been a more appropriate approach to  
30 behaviour management for this cohort of children and young  
31 people?

32 A. Well, while I have quite a bit of expertise and  
33 knowledge about behaviour management, I would actually  
34 suggest that the Australian Childhood Foundation would be  
35 the experts on what would be the absolute best approach,  
36 but you would be incorporating an understanding of trauma  
37 into that and identifying ways to help young people  
38 regulate.

39  
40 Q. Did you raise your concerns about the  
41 inappropriateness of the behaviour development system with  
42 centre management while you were the manager of  
43 Professional Services?

44 A. Consistently, yes.

45  
46 Q. Can you elaborate a bit for the Commissioners about  
47 the response you received from centre management when you



1 raised those concerns?

2 A. I think initially it was a - depends: the Centre  
3 Manager, there was an openness to look at other models.

4  
5 Q. Yes, that's Mr Ryan?

6 A. Yes. And some of the Senior Management Team were  
7 definitely open to conversations about that. I was at a  
8 meeting where I talked further about what we could be doing  
9 to improve that and that wasn't well received, so I feel  
10 like there was a lot of staff that the current behaviour  
11 development system was all they knew, so there was also  
12 quite a lot of resistance to changing it.

13

14 Q. And so, in that sort of a circumstance, would it be  
15 fair to say that you needed more than just an openness from  
16 senior management to changes, but actually changes needed  
17 to really be supported by and driven by senior management  
18 in order to get buy-in across the workforce?

19 A. Absolutely, yes.

20

21 Q. And, did you see that kind of intention or support  
22 from Mr Ryan?

23 A. There was a - he had a conversation with me that he'd  
24 raised it with the Director to look at a different  
25 behaviour management approach, but that's all. So, that -  
26 I was told that he had a conversation with the Director  
27 about it.

28

29 Q. You referred before to the Australian Childhood  
30 Foundation and it being the leading thinkers on behaviour  
31 management in traumatised children. Did you recommend any  
32 of their programs or literature to Mr Ryan at any point in  
33 time?

34 A. Yeah, I did on a number of occasions.

35

36 Q. And, was that in the context of discussions about the  
37 behaviour development system?

38 A. Yes.

39

40 Q. And, did he take you up on those suggestions?

41 A. No.

42

43 Q. You said there was an openness to consider other ways  
44 of managing behaviour but it seems there was no real  
45 substantive change to the way that behaviour was managed  
46 while you were at the centre.

47

1 Q. Do you have any reflections that you'd like to share  
2 with the Commissioners about what that says about the  
3 priority that was given to therapeutic practices at the  
4 centre?

5 A. Probably my reflection would be that I think they  
6 thought that the behaviour development system worked, for  
7 the staff to use it. I think the understanding of  
8 therapeutic practice was very low at the centre by  
9 operational staff; that's not to say all staff, but  
10 definitely very low by a lot of the operational management  
11 staff.

12  
13 Q. In circumstances where there was that low  
14 understanding within the Operations Team, and you were the  
15 manager of Professional Services and brought considerable  
16 expertise and also an ability to know where your expertise  
17 ended in an organisation like the Australian Childhood  
18 Foundation might assist, was deference given to your  
19 opinions in relation to behaviour management?

20 A. No, not at all. I probably heard more feedback that I  
21 didn't know what it was like to work with the young people  
22 in the centre, and I didn't work in the units day-to-day,  
23 so I was often - it was disregarded.

24  
25 Q. Is that another example of this command and control  
26 approach to the centre and to behaviour management winning  
27 out over the interests of the detainees?

28 A. I think so, and I also think it was an example of,  
29 that the Operations know more about working with young  
30 people and managing the young people than anyone else in  
31 the centre.

32  
33 Q. Ms Honan gave evidence on Friday that since you left  
34 the centre there have been changes and improvements to the  
35 Behaviour and Development, it's now called the Behaviour  
36 and Development Program. I'd be interested to know, having  
37 regard to your expertise, how you would objectively measure  
38 whether a new program was having a beneficial therapeutic  
39 impact on young people at the centre. Do you have any  
40 thoughts on objective measures that might suggest an  
41 improvement?

42 A. I don't have - I really don't know what the objective  
43 measures would look like, but I could describe to you that  
44 a young person leaving should have developed some  
45 regulation skills on leaving, so they would be able then to  
46 take those skills into the community and we would see them  
47 doing better in the community after they've left Ashley

1 than before they came in.

2

3 Q. Would you have measures - and having regard to the  
4 fact that the MDT is meeting on a weekly basis and the  
5 young people are being observed and monitored, would there  
6 be processes, business as usual processes at the centre  
7 that would allow improvements in behaviour to be tracked  
8 before they leave the centre?

9 A. If we actually were doing a behaviour - if we actually  
10 had a system in place that was therapeutic and helped young  
11 people to behave better, because their behaviour shows how  
12 well they are in themselves, really, you would expect to  
13 have everybody on green after a certain period of time and  
14 them not - when things become overwhelming for them, if  
15 we've got a therapeutic program in place they would learn  
16 to manage overwhelm and you wouldn't have young people drop  
17 straight back to a red colour, for example, because they've  
18 become - had a moment of escalation; so I would think you  
19 would start to see most of your young people tracking on  
20 those higher level colours of green and yellow because  
21 we've helped them to do so well.

22

23 Q. Self-regulate. Can I ask you about another colour.  
24 The behaviour development system when you were at the  
25 centre involved four colours, starting with the lowest risk  
26 behaviour, green, through yellow, orange and red. In March  
27 2019 something called the Blue Program was reintroduced; I  
28 understand you weren't involved in devising that program or  
29 re-introducing the program, but what was your understanding  
30 of what the Blue Program involved and why it was  
31 reintroduced?

32 A. My understanding of what was involved in it, I became  
33 aware of from an email, and I think that was also from my -  
34 could have been from someone in my team. And, initially  
35 the Blue Program - well, I understood the young persons  
36 spent a lot of time in their room or the unit, I'm not  
37 quite sure the amount of time that would have been, but it  
38 came through and the content of the Blue Program was a lot  
39 of PowerPoints that this young person was supposed to,  
40 like, read and work through with the youth worker.

41

42 Q. And is that because, while a detainee was on the Blue  
43 Program they were prevented from going to school outside  
44 the unit?

45 A. That's correct, yes.

46

47 Q. So, is it the case that they were effectively

1 responsible for their own learning by reference to a  
2 PowerPoint pack?

3 A. I think, my understanding was that I asked who worked  
4 through that PowerPoint, those Powerpoints with them and my  
5 understanding was, the youth worker was to work through  
6 them with the PowerPoint, yeah.

7  
8 Q. And is that something that youth workers were in a  
9 position to do having regard to their other  
10 responsibilities?

11 A. I don't know.

12  
13 PRESIDENT NEAVE: Q. And what was the capacity of the  
14 young people in Ashley who might have serious behaviour  
15 management issues; what was their general capacity to work  
16 through a PowerPoint program to understand the concepts  
17 which were being expressed and to take that in and use it  
18 to modify their behaviour, in general?

19 A. I don't think it was suitable at all to the capacity  
20 of the young people. We had young people with low literacy  
21 levels, the incapacity often - their cognitive capacity  
22 sometimes was quite low, and for the two people or the  
23 people that were on blue, I think they had some level of  
24 cognitive disability. I also expect that a lot of the  
25 young people in there had developmental delays, so weren't  
26 up to even necessarily able to read and understand, and a  
27 lot of it was quite high level reflective capacity was  
28 required.

29  
30 Q. So, to put this crudely, we're talking about a  
31 situation in which a young person with low cognitive  
32 capacity, poor reading skills, having somebody who's  
33 experienced perhaps serious trauma in the past is kept in  
34 their unit or kept in their room and required to work  
35 through a PowerPoint presentation, understand it and use it  
36 to modify their behaviour; is that the way it worked?

37 A. Yes, that's correct.

38  
39 PRESIDENT NEAVE: Thank you.

40  
41 COMMISSIONER BENJAMIN: Q. And added to that what you're  
42 saying is that the specialist educators at Ashley were  
43 excluded from that process?

44 A. Yeah, they weren't involved initially at all, no.

45  
46 Q. At least at the beginning?

47 A. That's right, yep.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

COMMISSIONER BENJAMIN: Thank you.

MS NORTON: Q. I've reviewed the literature surrounding the Blue Program, and you've helpfully exhibited a number of documents that were circulated at the time, and they are at pains to say that the blue classification doesn't involve punishment or isolation. Do you agree with those characterisations?

A. Well, the young people are removed from the general activities of the centre, which I would imagine a young people would feel like punishment; they were removed from communicating and interacting with their peers - you know, anybody else in the centre; yeah, I think it could have felt like punishment, yep.

Q. And appreciating that, while they weren't necessarily confined to their rooms at all times, they were "unit bound", I think is the term given to it at the centre. Is "unit bound" really a form of de facto isolation? Is that a fair characterisation or would you disagree with that?

A. I think we're definitely isolating people from the general routine of the centre, so I suppose it depends on the definition of "isolation" what that is.

Q. Is that a form of isolation?

A. It is, well, I think it is; it's isolating from all the other general activities of the centre.

COMMISSIONER BROMFIELD: Q. And their peers?

A. Yes, yep.

MS NORTON: Q. As I understand it, you had concerns about the Blue Program when it was first introduced, and you raise those concerns - they were raised initially with you by a member of your team, and then you raised them with Mr Ryan. What do you recall Mr Ryan's reception to those concerns being?

A. I remember him being open to improvement, I think his email response back to me - I made a number of suggestions on how it could be improved and he was quite open to looking at improvement, given that my team and my staff felt like we had some things we could contribute to improving it, yeah.

Q. What were you able to do in order to improve the Blue Program?

1 A. Well, we developed it very quickly and a bit on the  
2 run because, I think it had already been implemented. We  
3 based it on the principles of trauma-informed practice and  
4 attachment theory, which a lot of it came - I used quite a  
5 bit of theory from the Australia Childhood Foundation using  
6 relationship-based approaches. So, we developed an  
7 individualised program for each of those young people every  
8 day where we would have the professional staff go in every  
9 second hour to deliver a therapeutic content with the young  
10 person, so that would be the psychologist went in, someone  
11 from my team, the case managers, the education staff went  
12 and someone from Health. So then they had a full day's  
13 support program, and between those professional visits we  
14 designed some more calming regulation activities, so the  
15 gym, they went to the gym one-on-one with a youth worker.  
16 We asked them what else - other things - we consulted with  
17 the psychologist very quickly on some activities. So, some  
18 young people like doing jigsaws or some of those really  
19 like focused meditative activities to help with regulation.

20  
21 Q. In the Blue Program as initially devised by others was  
22 there a clear path out of blue back down through the other  
23 colours, or did you think there was uncertainty about how a  
24 young person would get off the blue classification?

25 A. My memory was, it was quite clear, because to get off  
26 blue you had to meet what had looked like to be sort of a  
27 red or orange, and as long as you participated in the Blue  
28 Program, or to some degree, and started to show some  
29 greater regulation, what looked like to be on the red  
30 colour, at the next CST meeting you would be up to that  
31 colour, or even before that, we had some interim CSTs so  
32 sometimes it would be sooner.

33  
34 Q. I was going to ask about that, because the CSTs  
35 happened once a week, and that's on a Monday. If you had  
36 somebody on the Blue Program who by the Wednesday is  
37 really, you know, meeting the requirements of red or  
38 another colour, the following Monday's quite a long time to  
39 wait to be reintroduced to the normal routine of the  
40 centre; so, is it your evidence that in those circumstances  
41 an interim CST meeting might be called to review that  
42 classification?

43 A. Yes, that's right.

44  
45 Q. The improvement that you've referred to, it sounds  
46 like you improved a program that was presented to you: did  
47 you think it was, following those improvements, a good

1 program or did you still have concerns about it?

2 A. I thought it was a good program in that it appeared to  
3 work; we had young people come off the blue colour into  
4 general activities much quicker once we implemented that.  
5 I wouldn't be able to say it was a good or great program  
6 because we didn't do enough evaluation, and really, we  
7 should be looking at really, was it meeting the individual  
8 needs for young people and how would we improve it.

9

10 COMMISSIONER BROMFIELD: Q. Did you still hold concerns  
11 about the level of isolation in the Blue Program once it  
12 had been modified by your team?

13 A. I had less concerns because they had someone with  
14 them - like, they had someone with them every second hour  
15 and some time between; I felt like there was more contact  
16 with people. The program was partly informed by an  
17 Australian Childhood Foundation program that I'd been to  
18 some training called, Holding Firm, and in that training  
19 and some of their principles - and I raised this in that  
20 training - about the use of some short-term containment for  
21 young people, so when they're really at risk to either  
22 themselves or others, short-term containment is required to  
23 maintain their own safety and the safety of other people.  
24 So, I would think that in the short-term sometimes you have  
25 to do that, but probably my concerns were that perhaps it  
26 was sometimes too long even the Blue Program, that we could  
27 have moved them back to the general activities each sooner.

28

29 PRESIDENT NEAVE: Q. What do you mean by short-term  
30 containment? Are you talking about half an hour, a day?  
31 What sort of period of time?

32 A. When I say containment, that would be containment -  
33 the Australian Childhood Foundation talk about containment  
34 within a relationship, so someone's there with you while  
35 you're in a contained environment, so it's always with  
36 someone there with you. And, we talked about how you would  
37 make that safe if someone was violent, and she talked about  
38 letting - even letting them know that there's someone  
39 outside the room always that they can talk to. The  
40 principles of both trauma-informed regulation and  
41 attachment theory is that we regulate with another person,  
42 not by ourselves; that's how regulation's learned. So,  
43 yeah, I mean, it was quite a crude improvement on the  
44 program, but I felt like it was better than what there was.

45

46 Q. So, to summarise what you're saying, the Blue Program  
47 was put in place without much or any consultation with the

1 professional team?

2 A. M'mm.

3

4 Q. The professional team then suggested some changes to  
5 it in order to overcome what the team saw as adverse,  
6 possible adverse effects?

7 A. Yep.

8

9 Q. If you'd started from, with no proposal for a Blue  
10 Program, you might not have gone down that track at all;  
11 have I got that right?

12 A. Yeah, absolutely, yep.

13

14 Q. But you were making attempts to improve it?

15 A. Yes, absolutely.

16

17 Q. And you think it did achieve perhaps some small gains?

18 A. Yes.

19

20 Q. Have I summarised that fairly?

21 A. Yes.

22

23 PRESIDENT NEAVE: Thank you.

24

25 MS NORTON: Thank you.

26

27 Q. I'd like to move on to ask you some questions about an  
28 incident that occurred involving harmful sexual behaviours  
29 in August 2019. If you'd like to get your pseudonym list  
30 out there, it's an incident in which one resident, Henry,  
31 was sexually assaulted by two other residents, Albert and  
32 Finn, using a drink bottle. Are you familiar with the  
33 event I've just described?

34 A. Yes.

35

36 Q. You attended a CST meeting on 12 August which was a  
37 few days after the event. Can you recall what the  
38 discussion at that CST was, and I'm directing you in  
39 particular to a discussion about what the response to  
40 Albert and Finn would be, in particular what colour they  
41 would be given. I think they were on yellow at the time.

42 A. The discussion at the meeting was that, as far as what  
43 colour they should be put on, other people in the meeting  
44 group suggested the orange colour would be the best colour  
45 because, if they were dropped to the red colour, which  
46 would have actually in the BDS been the appropriate colour,  
47 because you go to red if you've used assaultive behaviour



1 or a detention offence or something like that, but if they  
2 dropped to red they would drop their bundle and that would  
3 cause some behaviour problems that would be harder to  
4 manage in the centre and it would be better to put them on  
5 orange.

6  
7 Q. And, what view did you have about the appropriate  
8 classification? Is it that they should have been  
9 classified as red?

10 A. Absolutely, yes.

11  
12 Q. I understand that you raised some concerns following  
13 the meeting with Mr Ryan about the outcome of that  
14 discussion, that is, the classification as orange, and also  
15 you were concerned that the minutes of the CST meeting  
16 didn't reflect the actual discussion at the meeting; is  
17 that right?

18 A. That's correct, yes.

19  
20 Q. And is that because there was no reference in  
21 the minutes to there being dissent, that is, there being  
22 some people in the meeting who thought red was the  
23 appropriate classification?

24 A. Yes.

25  
26 Q. Was there any reference in the minutes to the  
27 rationale for orange over red being that, if the two  
28 detainees were put on red, they would drop their bundle?

29 A. No.

30  
31 Q. And was it a concern for you that minutes weren't  
32 reflecting the discussion at the meeting?

33 A. Yes, that was the concern, yes.

34  
35 Q. As I understand it from your statement, your view  
36 about the appropriate response to that incident is that  
37 Albert and Finn should have been put on red and there  
38 should have been very close supervision to manage safety  
39 for other residents. You also felt there should have been  
40 a notification to Child Safety Services and Tasmania  
41 Police, and you raised that view with Mr Ryan: what was his  
42 response?

43 A. From memory, his response was that we have different  
44 opinions on the matter.

45  
46 Q. And was that in relation to the colour classification  
47 or the decision about whether or not to refer the matter

1 externally or both?

2 A. Both, I think.

3

4 Q. I think you say in your statement that you sent an  
5 email to him outlining those concerns and it was initially  
6 ignored?

7 A. M'hmm.

8

9 Q. And you had to press for a response a week or so  
10 later. Were you satisfied with the response that you  
11 received from him then?

12 A. I can't remember the response.

13

14 Q. I think it's an email, it's Annexure I, I think, to  
15 your statement. I'll remind you, it's an email of  
16 22 August where he said:

17

18 *You're the leader of Professional Services*  
19 *and as such hold significant weight in*  
20 *these decisions.*

21

22 Again, do you think that that significant weight that  
23 should have been placed, in your view, was being honoured  
24 in reality?

25

26 PRESIDENT NEAVE: I'm sorry, what attachment was that?

27

28 MS NORTON: Attachment I, it's an attachment to the  
29 request for statement.

30

31 MS GARDINER: The response, I thought, was inadequate;  
32 that it left the responsibility for any further action with  
33 me to follow up.

34

35 MS NORTON: Q. You ultimately did report the matter to  
36 the Child Safety Service I think on 23 August. Based on  
37 your discussions with Child Safety, and I know you had a  
38 number of discussions following that initial contact, did  
39 Child Safety Services agree that this was an incident that  
40 you rightly reported to them?

41 A. Yes.

42

43 COMMISSIONER BROMFIELD: Sorry, Ms Norton, could you just  
44 clarify for us the date of the incident? I believe it was  
45 sometime in early August?

46

47 MS NORTON: Yes, 7 August, yes.

1  
2 COMMISSIONER BROMFIELD: So, 7 August, and then it was  
3 22 August, Ms Gardiner, that you made the report to Child  
4 Safety Services?

5  
6 MS NORTON: Q. It might be the 23rd, bearing in mind  
7 you'd waited or over a week to hear back from Mr Ryan in  
8 relation to your concerns?

9 A. That's correct.

10  
11 COMMISSIONER BROMFIELD: Thank you.

12  
13 MS NORTON: Q. We've talked about the proper  
14 classification for Finn and Albert going forward in terms  
15 of red or orange and that would have flow-on effects for  
16 their privileges over the coming week. But Finn and Albert  
17 were displaying harmful sexual behaviours, did you think  
18 there was an appropriate therapeutic response at the centre  
19 to those harmful sexual behaviours and the support that  
20 they might need to address those?

21 A. Not at all.

22  
23 Q. And, did you raise those concerns with Mr Ryan?

24 A. Yes, I did, in an email, and I also discussed it at  
25 the CST meeting.

26  
27 Q. And, were your concerns, not only listened to, but  
28 acted on?

29 A. No.

30  
31 Q. You say in one of your emails, and I think it's that  
32 same email that's Exhibit I - you're talking about the  
33 12 August CST meeting, and there was an explanation perhaps  
34 that was offered at that meeting, I'm not sure by who,  
35 that:

36  
37 *Both residents are long-term and would be*  
38 *experiencing some sexual frustration.*

39  
40 And that was offered as an explanation perhaps for why  
41 Finn and Albert had behaved as they did. Does that strike  
42 you as an appropriate characterisation for harmful sexual  
43 behaviours?

44 A. No.

45  
46 Q. Does it indicate an understanding of harmful sexual  
47 behaviours and their cause?

1 A. No, not at all.

2

3 Q. While you were at the centre did you see Mr Ryan or  
4 others taking up your suggestion that staff at the centre  
5 needed to become more skilled in assessing and responding  
6 to harmful sexual behaviours?

7 A. No.

8

9 Q. I anticipate that Mr Ryan will give evidence that he,  
10 as early as 2017, which I appreciate is before your time at  
11 the centre, but that he sought approval for harmful sexual  
12 behaviours training from his supervisors and from  
13 successive supervisors and that wasn't supported. Were you  
14 aware of those efforts while you were at the centre at all?

15 A. No, I wasn't. I was made aware he'd had discussions  
16 with the Sexual Assault Support Service, he'd referenced  
17 that, but I wasn't aware that he'd proposed any training  
18 from them and that it wasn't supported, no.

19

20 Q. Did you also have concerns - just going back to Henry  
21 who was the subject of this incident; he was a very  
22 vulnerable young person and, as I understand it, his care  
23 plan specifically said that he was not to be moved into a  
24 unit with Albert and Finn; is that your recollection?

25 A. I don't have a recollection of what was in the care  
26 plan.

27

28 Q. If that was the case, that the care plan said he  
29 should not have been moved into a unit, and it was the  
30 Franklin Unit, with those particular residents, would you  
31 have concerns about the fact that he was?

32 A. Absolutely, yes.

33

34 Q. And, there might have been operational reasons why  
35 that was considered necessary, but would you consider it  
36 essential in that circumstance that the detainees be  
37 subject to very close supervision?

38 A. Absolutely, yes.

39

40 Q. The final matter I'd like to ask you about --

41

42 COMMISSIONER BROMFIELD: Sorry, Ms Norton.

43

44 MS NORTON: Yes.

45

46 COMMISSIONER BROMFIELD: Q. You did mention that there  
47 was a lack of intervention for the two young people

1 displaying the harmful sexual behaviours. Do you recall if  
2 there was any kind of support provided for the young person  
3 who experienced that sexual assault?

4 A. I know that the psychologist saw that young person,  
5 yes.

6  
7 Q. And do you, again, based on your recollection, do you  
8 feel that all appropriate steps were taken in relation to  
9 that young person's sense of safety after that assault?

10 A. I don't think all appropriate steps were taken, no.

11  
12 Q. Is there anything that you wanted to expand on in  
13 relation to that assessment?

14 A. Well, because my advice was not followed and I wasn't  
15 included in any of the following planning for that, I  
16 couldn't be sure that their safety was secured, I couldn't  
17 be sure how they felt or what would meet their needs best.  
18 Yeah, I felt like it should have been a really  
19 collaborative management approach to responding to that,  
20 and I really wasn't part of that.

21  
22 Q. From your experience in this field, what could it  
23 prompt in a young person who had experienced a sexual  
24 assault like that, to then be in a situation where they're  
25 forced to be in close proximity to their perpetrators or to  
26 reside in the same unit with them?

27 A. Well, that's just further trauma, isn't it; it could  
28 be quite terrifying, yeah.

29  
30 Q. Is that, in your experience, a trauma-informed  
31 practice? Is that likely to contribute in any way to  
32 behavioural escalation?

33 A. Absolutely, yes, yep. There's a lot of risks  
34 associated with how the young person may then modify their  
35 behaviour to keep themselves safe.

36  
37 COMMISSIONER BROMFIELD: Thank you. Sorry, Ms Norton.

38  
39 MS NORTON: Thank you.

40  
41 Q. I'm conscious of the time, there's just one final  
42 matter I'd like to ask you about and it concerns a detainee  
43 called "Max" who also should be on your pseudonym list  
44 there. This is not long after the incident with Henry,  
45 Finn and Albert. I'm just trying to get a date for you.  
46 It's page 29 of your statement. In any event, if you could  
47 just accept that it's a short time after the incident

1 involving Henry, Finn and Albert.

2  
3 Max was a particularly vulnerable young person and he  
4 was put in the Franklin Unit, again, with Finn and Albert.  
5 He had himself displayed sexualised behaviours so putting  
6 him with Finn and Albert exposed him to risk and it also  
7 exposed Finn and Albert to risk having regard to their  
8 propensity to engage in harmful sexual behaviours.

9  
10 You say in your statement at about page 47 that you,  
11 again, had conversations with Mr Ryan about the decision to  
12 place Max in Franklin, which I think again your team was  
13 not consulted about. What do you recall about Mr Ryan's  
14 response on that occasion?

15 A. He told me to read the Unit Moves Procedure, which I  
16 read, and the Unit Moves Procedure at the time didn't  
17 involve any consultation with Professional Services or  
18 consideration of the MDT group about risks for young  
19 people, so I let him know that the current procedure puts  
20 young people at risk; that I'd read it but it still created  
21 risks for young people.

22  
23 Q. And was that because there was a risk that operational  
24 considerations would dictate moves without regard to safety  
25 issues that that those moves might present for the young  
26 people?

27 A. Yes.

28  
29 Q. Following your review of the Unit Moves Policy, did  
30 you have a further discussion with Mr Ryan?

31 A. Yes.

32  
33 Q. What do you recall about that discussion?

34 A. I'm not sure whether it was in an email or in  
35 conversation, but I let him know that the current procedure  
36 as it stands, with no consultation with Professional  
37 Services or the MDT Group puts young people at risk.

38  
39 Q. And, did he show an openness or act on your concern by  
40 making changes to the Unit Moves Procedure?

41 A. No.

42  
43 Q. I think you say in your statement that it was a  
44 discussion, not via email but in person, and that he,  
45 again, yelled at you to read the procedure: do you recall  
46 that?

47 A. Yes.

1  
2 Q. Out of fairness, I think Mr Ryan's going to give  
3 evidence that he didn't yell at you. Do you have a clear  
4 recollection of that discussion?

5 A. I remember being told very bluntly to "Read the Unit  
6 Moves Procedure".  
7

8 MS NORTON: Thank you, Ms Gardiner, I have no further  
9 questions for this witness.  
10

11 PRESIDENT NEAVE: Q. I just have one question before I  
12 ask my colleagues. I suspect that one of the issues that  
13 will be raised later on in this week will be about the  
14 resourcing and the capacity for Ashley as it's currently  
15 staffed to adopt therapeutic procedures. Do you have any  
16 comments on the sort of resourcing you would need to  
17 overcome some of the issues that we've discussed today?

18 A. My comment about resourcing would - I think that the  
19 staff, a significant number of staff working with young  
20 people need to be tertiary trained. I think staff need to  
21 operate understanding principles and the theory of  
22 practice. Because of the complexity of the young people  
23 they're working with, it's about the interpretation, the  
24 work is so nuanced with the individual young person that  
25 understanding the principles, yeah, and theories of  
26 practice to inform decision making in the application of  
27 rules. I feel like, when staff are operating from  
28 certificate-based training, they've learnt the rules and  
29 processes to work with young people, but not how you would  
30 interpret that to be in the best interests of young people.  
31 So, similar to where you see in Health Services or complex  
32 Human Services where you have degree qualified people,  
33 they're able to interpret what would be in the best  
34 interests of this person, even though the rules tell us  
35 this, and perhaps the rules are not good then and what do  
36 we do to change the rules or influence the rules?  
37

38 Q. The government has announced that Ashley will be  
39 closed and that there will be two separate Youth Detention  
40 Centres. Do you have any comments about the sort of level  
41 of staffing you might need if you were going to have a  
42 centre, say, in Launceston and Hobart, apart from the issue  
43 of professional qualifications that you've discussed? What  
44 are we talking about in terms of ratios of staff to young  
45 people that are necessary to do this very difficult work?

46 A. I think one-to-one would be ideal, but I think there  
47 could be some young people that you could work at a ratio

1 of, like, one staff member to two depending how they are.  
2 I think any further than that you're not really able to  
3 help young people regulate and manage and step in in a  
4 timely manner where you need to.

5  
6 PRESIDENT NEAVE: Thank you.

7  
8 COMMISSIONER BENJAMIN: Q. Just so I can understand the  
9 issue regarding Max, and that was in August 2019, was it  
10 that or thereabouts?

11 A. I can't remember the timing.

12  
13 Q. I think you said it was shortly after the events. It  
14 was around that area of time anyway.

15  
16 MS NORTON: Yes, it's around the third week in August.  
17 There's an email in relation to this, that you sent to the  
18 operations manager on 21 August.

19 A. Yes.

20  
21 COMMISSIONER BENJAMIN: Q. Was Max a younger child,  
22 compared to Finn and Albert?

23 A. Yes.

24  
25 Q. Considerably younger?

26 A. A couple of years younger.

27  
28 Q. And was there any difference in the physical size of  
29 Max as against Finn and Albert?

30 A. Max was quite a big boy, quite tall and quite - yeah,  
31 he was quite a big boy, so he was bigger, yeah.

32  
33 COMMISSIONER BENJAMIN: Thank you.

34  
35 COMMISSIONER BROMFIELD: I didn't have any further  
36 questions. Thank you for your evidence.

37  
38 PRESIDENT NEAVE: Thank you. I'm sorry, I don't mean to  
39 cut you off.

40  
41 MS NORTON: No. I was just going to say that when we're  
42 finished with the witness, then I think it's, subject to  
43 your convenience, time to break for the morning break.

44  
45 PRESIDENT NEAVE: Thank you. I wanted to thank you very,  
46 very much for your careful statement and your evidence  
47 today. Thank you.



1 A. Thank you.

2  
3 **SHORT ADJOURNMENT**

4  
5 MS ELLYARD: Thank you, Commissioners, the next witness is  
6 going to give evidence of her experiences, the Commission's  
7 directed that she be known as "Erin". Can I ask that a  
8 direction be given for the live stream be turned off for  
9 the purposes of her evidence?

10  
11 PRESIDENT NEAVE: Yes, could you do that, please?

12  
13 MS ELLYARD: Thank you, I understand the live stream is  
14 off, so Erin, I'll just ask you to stand so that you can  
15 make your promise to tell the truth.

16  
17 **<ERIN, affirmed: [11.57am]**

18  
19 **<EXAMINATION BY MS ELLYARD:**

20  
21 MS ELLYARD: Q. Erin, you're here today to read a  
22 statement about some of your experiences when you were a  
23 resident at Ashley Youth Detention Centre; is that right?

24 A. Yes.

25  
26 Q. You've written a statement which is about some of your  
27 experiences, not all of them?

28 A. Yes.

29  
30 Q. And, for the purposes of today, you're going to read  
31 some of that statement, not all of it, because you've made  
32 a decision about what you feel comfortable reading and what  
33 you'd prefer not to read; is that right?

34 A. Yes.

35  
36 Q. Can I invite you to read your statement now, take your  
37 time?

38 A. Sure, okay:

39  
40 *When I was 14 years old I started playing*  
41 *up at school.*

42  
43 Sorry, is that microphone, okay, sorry:

44  
45 *When I was 14 years old I started playing*  
46 *up at school. It was nothing too serious,*  
47 *just things like smoking and wearing too*

1           *much make up. As a result my mum decided*  
2           *to put me in Annie Kenney which is a*  
3           *woman's shelter which is a women's shelter*  
4           *providing short-term crisis accommodation*  
5           *in Hobart. There was about 14 other girls*  
6           *in the shelter, they were all older than me*  
7           *up to the age of 21.*

8  
9           *From this time things escalated pretty*  
10          *quickly. Annie Kenney will kick you out*  
11          *between 9am and 5pm each day. I started*  
12          *spending my days hanging around with other*  
13          *girls from the shelter.*

14  
15          PRESIDENT NEAVE: Erin, I don't want to make things  
16          difficult for you, but if you could speak just a little bit  
17          slower it's easier for us to follow.

18          A. Sure, sorry, I'm just a bit nervous.

19  
20          COMMISSIONER BROMFIELD: Take a break, have some water and  
21          know that we have plenty of time to hear you, you don't  
22          need to rush anything, we want to hear everything.

23  
24          PRESIDENT NEAVE: We want to hear what you have to say to  
25          us.

26  
27          ERIN:

28  
29                 *I stopped regularly attending school. I*  
30                 *had no money, no clothes and no food. I*  
31                 *was too young to receive money from*  
32                 *Centrelink so I started stealing.*

33  
34                 *In [REDACTED] when I was 14 and a half I*  
35                 *was caught stealing a bag of Doritos which*  
36                 *I stole because I was hungry. I wanted*  
37                 *dinner and had planned to make nachos.*  
38                 *After this I was arrested. The police*  
39                 *called my [REDACTED] to come and get me. He*  
40                 *told the police that he didn't want me and*  
41                 *they could keep me.*

42  
43                 *I was left in the Hobart Remand Centre for*  
44                 *two days. I was strip-searched by male*  
45                 *guards. I didn't shower or eat. Adult*  
46                 *male prisoners would watch me.*

1 I was sent to the court twice but they  
2 didn't know what to do with me. My parents  
3 didn't want me and all of the shelters were  
4 full. I was too old for foster care.  
5 While I had some prior offences I didn't  
6 think I was out of control in any way, they  
7 just didn't know what to do. As a result  
8 they sent me to Ashley Youth Detention  
9 Centre (Ashley) on remand. I stayed there  
10 for three months.

11  
12 By the time they told me I was going to  
13 Ashley I was relieved. I thought going  
14 there would provide me with some sort of  
15 security. I thought Ashley would be better  
16 but it turned out to be worse.

17  
18 When I arrived at Ashley, I was  
19 strip-searched by male guards, I didn't  
20 think much of it at the time because it had  
21 already happened to me at the Remand  
22 Centre. I will provide more detail about  
23 being strip-searched later in this  
24 statement.

25  
26 I was told that they hadn't had a girl in  
27 Ashley for about 18 months prior to me  
28 going in there, and when I arrived I was  
29 the only girl. When the boys saw me they  
30 were thrilled. I instantly had the boys  
31 yelling things out to me and banging on my  
32 windows.

33  
34 The layout of Ashley at the time was, the  
35 girls unit, [REDACTED] was joined to  
36 [REDACTED] which was one of the boys  
37 units. I didn't realise initially but the  
38 boys in [REDACTED] could watch me through  
39 the guards' office.

40  
41 I was unit bound for the first week which  
42 was part of the normal introduction. This  
43 happened every time I went to Ashley. I  
44 was kept in the unit by myself that week  
45 and only allowed out for an hour or two a  
46 day. I've got massive trauma from this. I  
47 can't deal with being trapped inside. I

1 found the COVID lockdowns really hard.

2

3 The first significant incident occurred  
4 after I had only been at Ashley for about a  
5 month. I was feeling unwell with stomach  
6 pains and I thought I had appendicitis. I  
7 told the male worker on shift, who I would  
8 prefer not to name in this statement, that  
9 I was unwell and I needed to go and see the  
10 nurse. He told me he would have a look for  
11 me. He got me to lie on a chair in the  
12 unit and lift my top up. He then proceeded  
13 to feel around my body, nowhere near my  
14 appendix. He drew a jellybean thing on me  
15 and told me it was a "happy appendix". He  
16 didn't take me to see the nurse.

17

18 I knew that it wasn't okay for him to do  
19 this to me so I decided to speak to one of  
20 female workers. I thought what he did was  
21 creepy and I felt really violated. The  
22 female worker told me that it wasn't okay  
23 for him to do that to me and I should  
24 report it to the Ombudsman. I called the  
25 Ombudsman and told them what had happened  
26 and that it wasn't okay. Two weeks later I  
27 got back a generic letter from them saying  
28 that the complaint would be handled  
29 internally and that they wouldn't make  
30 contact with me again. I have kept a copy  
31 of this letter.

32

33 And then attached there's a letter.

34

35 None of the staff at Ashley spoke to me  
36 about what had happened and I wasn't  
37 offered any counselling, support or  
38 mediation. I wasn't notified of any  
39 outcomes. The male guard got two weeks  
40 paid leave. [REDACTED]

41

42 [REDACTED]. I was  
43 told by one of the workers that this was  
44 because of my complaint but I was never  
45 formally told about this.

45

46 When the male worker [REDACTED] returned  
47 to Ashley I had to continue working with

1           *them, they were never nice to me again.*

2

3           *Other staff were pissed off at me for*  
4           *speaking up and going to the Ombudsman.*  
5           *They would tell me that I was a dog and a*  
6           *drama queen. After this I felt like it was*  
7           *pointless making complaints or speaking up.*  
8           *I learned that you don't say anything in*  
9           *Ashley, it was more trouble than what it*  
10          *was worth. I would describe the staff at*  
11          *Ashley as being like a pack of animals.*  
12          *Some of them had been working there for*  
13          *30 years. They all went to school*  
14          *together. They were all from Deloraine*  
15          *which was a small country town. They all*  
16          *looked after each other*

17

18          COMMISSIONER BROMFIELD:    Q. Do you want to take a breath?

19          A. Yes, please.

20

21                 *At Ashley we had to attend compulsory*  
22                 *school and therapeutic based programs.*  
23                 *Because I was either the only girl or one*  
24                 *of few girls at Ashley I would always be*  
25                 *mixed in with the other boys. On one*  
26                 *occasion I was left in a room by myself*  
27                 *with about 10 other male detainees and no*  
28                 *worker supervising. In this time I was*  
29                 *sexually assaulted. I shouldn't have been*  
30                 *left alone with these boys, the staff had a*  
31                 *duty of care to look after me.*

32

33                 *After I left the program I told another*  
34                 *girl who was in Ashley at the time what had*  
35                 *happened to me. I told her not to tell*  
36                 *anyone because they would call me a dog and*  
37                 *I'd get my head kicked in. She decided to*  
38                 *tell a female worker.*

39

40                 Sorry.

41

42          PRESIDENT NEAVE:    Just have a little drink of water and  
43          just ...

44

45          COMMISSIONER BROMFIELD:    As much time as you need, and you  
46          can take a break if you want one.

47

1 ERIN:

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

*She decided to tell the female worker who had previously advised me to go to the Ombudsman.*

PRESIDENT NEAVE: Would you like our counsel to read the rest of your statement?

A. No, I'm fine.

PRESIDENT NEAVE: Good, thank you.

A.

*Later that night the female worker came in to my cell and asked me what had happened. I broke down and told her everything. Again I asked her not to tell anyone. Despite me asking her not to tell anyone, the female worker reported the workers for leaving me alone and the main boy who assaulted me. I wasn't offered any counselling or given any medical attention despite the fact that I was in pain. Nobody else from Ashley came and spoke to me about had happened.*

*I recall that my parents were phoned about the incident despite me not having anything to do with them. Two or three days later I was released from Ashley and that was it, end of story.*

*About a month after being released from Ashley I was again arrested for stealing. I didn't have any clothes because the other girls in the shelter had taken all of my clothes. I was done for stealing a bag of clothes and some makeup.*

*After going through the Remand Centre I was again sent t Ashley on remand. This time I was there for a month and a half.*

Sorry:

*When I arrived at Ashley I was told by a worker in admissions that the boys were going to hate me. I asked why and she told*

1 me that the main boy who had assaulted me  
2 had [REDACTED]. He was  
3 already over 18 at the time he assaulted me  
4 and had a history of violence. This was  
5 the first I heard of the outcome. Because  
6 of this as soon as I got in I was hated.

7  
8 After I went through admissions, I walked  
9 through the yard where all of the boys  
10 were. They barked and yelled at me.

11  
12 Friends of the boys who got transferred  
13 told me they were going to kick my head in  
14 and I wasn't allowed to come out of my  
15 room. Some of these boys were also over  
16 the age of 18. The workers hated me too  
17 because they got told off for what had  
18 happened. I wasn't offered any support or  
19 protection to help me deal with all of  
20 this. There was no-one there to support  
21 me. This again confirmed to me that you  
22 don't say anything at Ashley. If things  
23 happen you don't talk, you just go along  
24 with it.

25  
26 With all of this going on I had decided if  
27 I would continue to fight or just go along  
28 with it. I decided to just go along with  
29 it because that was easier.

30  
31 I went back to Ashley on two more  
32 occasions, both times for breaching my  
33 curfew which was a part of my bail  
34 conditions. The third time I was there for  
35 two weeks. When I got out, which was right  
36 before [REDACTED], I broke my curfew again  
37 that night and I was taken back to Ashley  
38 the following day and held on remand for  
39 around another five months. Overall I went  
40 to Ashley four times between [REDACTED]  
41 [REDACTED] for a period of about 10 months.  
42 My experience during the second, third and  
43 fourth admission were pretty much the same.  
44 I was put back in programs with some of the  
45 boys that had been involved in the assault.

46  
47 The guards knew things were happening but

1           *they would just accept it. They would*  
2           *leave me unattended all the time and the*  
3           *boys knew they could get away with things.*  
4           *Eventually I was put on the contraceptive*  
5           *pill. I would go to the nurse's office*  
6           *every day to receive it.*

7  
8           COMMISSIONER BROMFIELD:   Q.   Do you want to have another  
9           sip of water and give yourself a moment?

10          A.   Yes. Thank you. Sorry, I'm just trying to figure  
11          out, sorry.

12  
13          Q.   You can take your time.

14  
15          COMMISSIONER BENJAMIN:   Q.   I think you just told us  
16          you'd been there from [REDACTED] to [REDACTED], that was the spot you  
17          were up to.

18          A.   Yes.

19  
20          Q.   But take your time.

21          A.   Sorry, there's just one part and I've just --

22  
23          Q.   Don't apologise, it's important that you tell us your  
24          story.

25          A.   I am going to alter it slightly so, I'm sorry in  
26          advance, as previously - sorry.

27  
28          COMMISSIONER BROMFIELD:   Q.   Do you want a couple  
29          of minutes to write down something different?

30          A.   Sorry, I'm just - I'm fine.

31  
32          MS ELLYARD:   May I interrupt, and I'm sorry to interrupt,  
33          Erin. I think I'm aware in a general sense of certain  
34          aspects of Erin's statement that she's concerned not to  
35          read out loud and I think one way to do that is for me to  
36          ask for a restricted publication order that refers to  
37          locations within the centre where the things that Erin has  
38          described occurred, and to the particular time periods so  
39          that, even though Erin might read something out, there  
40          won't be any publication of the time periods or the  
41          locations within the centre where particular events  
42          occurred, and that may assist in helping her feel she can  
43          read what's there without it being published beyond this  
44          room.

45  
46          PRESIDENT NEAVE:   Q.   And, Erin, you would find that  
47          helpful?



1 A. Yes, please.

2

3 PRESIDENT NEAVE: Yes, we'll certainly make that order,  
4 and I might need to get the terms of the order right, but  
5 it's in relation to the locations and times at which  
6 various events occurred.

7

8 MS ELLYARD: Yes, we'll get the form of order but for now  
9 in case there's any media already listening if they could  
10 be alert to the fact that, to the extent that particular  
11 locations have been identified as to the place where events  
12 occurred, there should be no publication of those  
13 locations.

14

15 PRESIDENT NEAVE: Thank you.

16

17 ERIN: I would really appreciate that, thank you. Sorry,  
18 can you hear me? There we go.

19

20 Okay, so just to confirm, if the media can just be  
21 respectful of just locations and times.

22

23 PRESIDENT NEAVE: Of course, yes.

24

25 Q. So that means that you don't need to sort of edit as  
26 you go?

27

28 A. Yeah, okay. All right:

29

30 *There was one program, it was [REDACTED]  
31 [REDACTED] of the centre. [REDACTED]*

32

33 *The workers would either watch or go to  
34 sleep. While the class was going I would  
35 have to give handjobs to the boys that were  
36 there. This would happen every week.*

37

38 *Sometimes the workers would watch and I  
39 would ask them if they were going to say  
40 something. They wouldn't say anything,  
41 they were just happy watching. I went  
42 along with doing these things because I  
43 just thought it was easier. I believed  
44 that if I didn't I would get my head kicked  
45 in. It was easier to comply. I didn't  
46 make complaints to the staff because I knew  
47 if I did things would get worse. Again, I*

1           *was fearful of being physically assaulted.*

2

3           *The whole environment at Ashley was*  
4           *hostile. The guards would do things to*  
5           *make your life hard. If the guards didn't*  
6           *like you they would do things like leave*  
7           *you in your cell on the weekend. They*  
8           *would tell you that it was 6 o'clock in the*  
9           *morning when actually it was 10 o'clock.*  
10          *They would leave the curtain up over your*  
11          *door so you couldn't see the sun and didn't*  
12          *know what was going on around you. You'd*  
13          *miss out on your lunch and they wouldn't*  
14          *let you out of your cell until, like,*  
15          *1 o'clock in the afternoon. They did these*  
16          *things to mess with you and make your life*  
17          *really hard. They would also use the*  
18          *points and colour system to take privileges*  
19          *away and make your life harder.*

20

21          *I was pretty lucky when it came to physical*  
22          *assault. I was never physically assaulted*  
23          *by the guards but I witness them assault*  
24          *the boys really badly. They would break*  
25          *arms and legs. I knew that they could do*  
26          *this to me so I was never violent or*  
27          *aggressive. They would just do more*  
28          *manipulative things to me.*

29

30          *The guards would constantly make comments*  
31          *about my body and my breasts. They*  
32          *wouldn't let me wear a bra. I was treated*  
33          *like an object. That's what I was*  
34          *targetted as. I remember when I was 14*  
35          *being told that I was* [REDACTED]

36

37

38          *If that description can also please be cut out.*

39

40          *I wasn't allowed to have a bra in either*  
41          *Ashley or the Remand Centre. This is*  
42          *something that I didn't make complaints*  
43          *about. Every week at Ashley we were able*  
44          *to put in requests. I think the requests*  
45          *went to centre management. They were*  
46          *usually used for requesting things like*  
47          *another football but every week I would put*

1 one in asking if I could have a bra. I  
2 would list different reasons, like my back  
3 hurts, it's uncomfortable or everyone can  
4 see my boobs but I never got one. They  
5 told me if I got sentenced I would be  
6 allowed to have a bra but I never got  
7 sentenced, I was always in Ashley on  
8 remand.

9  
10 I wasn't even allowed tampons when I was in  
11 Ashley. They told me that the girls had  
12 abused the privilege of having tampons in  
13 the past so we weren't allowed them. That  
14 was it. We were allowed to have pads but  
15 we were only allowed so many at a time. I  
16 raised this as an issue through the same  
17 request process but was told we just  
18 weren't allowed tampons. There was no  
19 dignity, it was disgusting.

20  
21 Strip-searches would occur all the time.  
22 There was no need for them. I would be  
23 searched each time I was admitted, before  
24 court, after court and when they were doing  
25 random searches. They would do the random  
26 searches as part of the sweep of the  
27 centre. There would never be any reason  
28 for them.

29  
30 The random searches would occur in either  
31 the admissions area or in my room.  
32 Sometimes when I was searched there would  
33 be two or three male guards at once  
34 conducting the search. They would tell me  
35 there had to be two or three guards  
36 watching for my protection because I was a  
37 female. They would tell me to remove one  
38 item of clothing at a time until I was  
39 completely naked. They would get me to  
40 move my breasts around, there was no  
41 dignity, it was totally violating, it was  
42 like a show for them but they would justify  
43 all of them watching so I couldn't say  
44 things that had happened. It was so  
45 twisted.

46  
47 I was never given the option for a female

1 to do the search. For so long I believed  
2 it was okay for them to search me like this  
3 particularly because it had happened to me  
4 in the Remand Centre. It was normalised,  
5 now I realise how messed up it was.  
6

7 Sorry:  
8

9 One particular occasion I remember was  
10 during my fourth time at Ashley. I had  
11 changed the sheets on my bed and asked the  
12 male worker to come and collect them. I  
13 had been waiting hours for him to collect  
14 them but he didn't. Eventually I told him  
15 that I was having a shower and going to  
16 bed. Five minutes later he came into my  
17 room to get the sheets. He came right into  
18 my room and watched me in the shower. He  
19 wasn't in my room for very long but there  
20 was no reason for him to be there. I had  
21 intentionally left the sheets at my door so  
22 he couldn't come in. I think by this time  
23 the guards knew I wouldn't say anything so  
24 they just did what they wanted. There was  
25 nothing subtle or sneaky by this point.  
26 They just didn't care.  
27

28 One thing I don't think is spoken about  
29 enough is the Hobart Remand Centre. For me  
30 the Remand Centre really sets the tone.  
31 The Remand Centre would give jobs to the  
32 male prisoners. Because of these jobs I  
33 was forced to interact with them. These  
34 prisoners were there for their protection  
35 so they were often rapists and paedophiles  
36 serving long sentences.  
37

38 For me this is completely messed up. On  
39 one occasion I remember I was in my school  
40 dress and the guards hosed me down. I was  
41 left in my cell with a dripping wet  
42 see-through school dress with all of the  
43 prisoners walking past looking at me and  
44 chatting to me. I felt like I was being  
45 put on display.  
46

47 The conditions of the cells in the Remand

1 Centre were disgusting. The cells were  
2 often not cleaned out from beforehand, so  
3 there would be piss, shit and food all  
4 through the cell from the previous prisoner  
5 when you arrived.  
6

7 Sorry, and that's about it. But, the impact of my  
8 abuse:

9  
10 Coming out of Ashley I went down a massive  
11 spiral. It's hard to put into words. I  
12 started using ice, speed and smoking bongos.  
13 I drank a lot. This was my way of blocking  
14 things out and helping me forget. I now  
15 think there's more that happened to me in  
16 Ashley that I have permanently blocked out.  
17

18 I've got PTSD, anxiety and depression. I  
19 struggle to trust males in particular. It  
20 impacts my relationships, which now impacts  
21 my children. I have got really low  
22 self-esteem. It's embarrassing and not  
23 something that other people my age can  
24 relate to.  
25

26 Constantly being sexualised has really  
27 impacted who I am today. Being treated  
28 like that every day over so many months at  
29 such a young age, it really impacted who  
30 I am as a person. I've been involved in  
31 abusive relationships that I have never  
32 spoken up about. Ashley made me feel like  
33 it was normal and it was okay for men to  
34 treat me like that. It made me believe  
35 that it was what I was used for. I have  
36 had horrendous things happen to me that I  
37 have just thought I deserved. I believed  
38 that it was normal for these things to  
39 happen because that's how I was treated at  
40 such a young age. Before I went to Ashley,  
41 I was never exposed to sexual abuse.  
42

43 What could be improved?

44  
45 What happened to me could have 100 per cent  
46 been prevented. If girls weren't put in  
47 with the boys, most of this stuff would

1 never have happened. Girls and boys  
2 shouldn't be put in together. I was  
3 exposed to a lot because of this and it has  
4 changed me as a person. It took away my  
5 innocence.

6  
7 If there was a majority of female workers,  
8 stuff with the guards never would have  
9 happened. The staff at Ashley also didn't  
10 have adequate training. They had been  
11 there since the '80s just staying in their  
12 role.

13  
14 Children should not be sent to a place like  
15 Ashley for minor offences. I was there for  
16 stealing a bag of Doritos. Children  
17 shouldn't be sent so to Ashley for these  
18 crimes. If detention is need, it could be  
19 a home detention somewhere like Annie  
20 Kenney. I remember being spoken to about a  
21 home detention-based system where four or  
22 five kids could be kept together and those  
23 could be all around the state. I thought  
24 that was a really good at the time, and I  
25 still think it's a good idea now. I don't  
26 know why we aren't doing it.

27  
28 Building a new centre and putting a ribbon  
29 on it isn't going to change anything. They  
30 need to break it right down and make sure  
31 it changes. I have heard that the new  
32 centres are going to be therapeutic-based,  
33 but just saying that isn't enough. Ashley  
34 had what was supposed to be a  
35 therapeutic-based system when I was there.  
36 The [REDACTED] programs where I was  
37 made to give the boys handjobs were a part  
38 of this therapeutic-based system.

39  
40 PRESIDENT NEAVE: Erin, thank you so much for your great  
41 courage. What you've told us will help other children in  
42 the future. You've given us an enormous amount of help,  
43 and we're very, very grateful to you. We know what an  
44 ordeal it was for you to have to speak about what has  
45 happened to you.

46 A. Thank you.  
47

1 Q. And we hope that your future is brighter than what has  
2 happened to you and that things will get better as time  
3 moves on.

4 A. Thank you.

5  
6 PRESIDENT NEAVE: So, thank you very, very much indeed.

7  
8 MS ELLYARD: Commissioners, may I invite you perhaps to  
9 stand down for a couple of minutes. We'll bring the live  
10 stream back up and we'll arrange for the next witness to  
11 come into the hearing room.

12  
13 **SHORT ADJOURNMENT**

14  
15 MS ELLYARD: Thank you, Commissioners. There's an  
16 appearance to be announced on behalf of the next witness.

17  
18 MS WEISS: Thank you, counsel. It's Regina Weiss  
19 appearing today for the next witness. Thank you.

20  
21 MS ELLYARD: There's a restricted publication order in  
22 place, so that the next witness is to be referred to as  
23 "Alysha", and I'll ask her to stand so that she can take  
24 the affirmation.

25  
26 **<ALYSHA, affirmed:** [12:27]

27  
28 **<EXAMINATION BY MS ELLYARD:**

29  
30 MS ELLYARD: Q. Take a seat, Alysha, and make sure  
31 you've placed yourself in front of the microphone so we can  
32 hear you. You've made a statement to assist the work of  
33 the Commission; is that right?

34 A. That's right.

35  
36 Q. You've got a copy of that statement in front of you?

37 A. I do.

38  
39 Q. It's dated 16 August 2022, and I understand there are  
40 a couple of minor corrections that you'd like to make. The  
41 first is to paragraph 213. As I understand it, you refer  
42 there to children who are known by pseudonyms, and there's  
43 an error so that the three references in paragraph 213 to  
44 "Joseph" should be references to "Richard"?

45 A. Correct.

46  
47 Q. The second change, as I understand it, is in

1 paragraph 228. In the third-last line of that  
2 paragraph there are words which say, "the same incident".  
3 As I understand it, you would like to change that to say  
4 "another incident as referred to in paragraph 58"?

5 A. That's right.

6

7 Q. And then the final change is in paragraph 276. On the  
8 fourth line of paragraph 276, it says, "which upset V  
9 greatly". That should read "which upset Margaret greatly"?

10 A. Correct.

11

12 Q. With those changes made, and noting that in the public  
13 version of your statement there will be some redactions for  
14 other names, are the contents of your statement true and  
15 correct?

16 A. Yes.

17

18 Q. Thank you. As we learn from your statement, Alysha,  
19 you worked at Ashley Youth Detention Centre for a period of  
20 slightly over six months between October 2019 and April  
21 2020?

22 A. That's right.

23

24 Q. You explain in your statement that since April 2020  
25 you've been on leave?

26 A. Yep.

27

28 Q. And the circumstances of you taking leave are the  
29 subject of legal proceedings between you and the State?

30 A. That's right.

31

32 Q. And we're not dealing in detail with those matters for  
33 the purposes of this statement.

34 A. Yep.

35

36 Q. The role that you had during the time that you were at  
37 Ashley was the role of clinical practice consultant?

38 A. That's right.

39

40 Q. In your role, you had the responsibility for assisting  
41 youth workers to improve the way in which they worked with  
42 the young people?

43 A. Yes.

44

45 Q. And, as part of that, you formed part of what we  
46 understand was called the Professional Services Team?

47 A. That's right.



1  
2 Q. But you also worked with members of the Operations  
3 Team?  
4 A. Yep.  
5  
6 Q. Because part of your role was to work with them to  
7 improve their practice?  
8 A. Exactly.  
9  
10 Q. And that, as I understand it, could involve meeting  
11 one-on-one with them for supervision?  
12 A. Yep, absolutely.  
13  
14 Q. And it also involved you being part of various  
15 meetings, which we're going to talk about?  
16 A. Yes.  
17  
18 Q. So, at paragraph 23 of your statement you describe the  
19 organisational structure of the centre. And, as I  
20 understand it, during the period of time you were there the  
21 manager of the centre was Patrick Ryan?  
22 A. That's right - well, for the majority of the time,  
23 yes.  
24  
25 Q. And quite towards the end he went on leave and he was  
26 replaced by Mr Watson?  
27 A. Correct.  
28  
29 Q. Would it be fair to say that the observations that you  
30 make about the culture and management style during your  
31 time are largely observations about Mr Ryan?  
32 A. Yes.  
33  
34 Q. And about another person who we're calling "Lester"?  
35 A. Correct.  
36  
37 Q. And they're not so much about Mr Watson?  
38 A. No.  
39  
40 Q. Thank you. You've described in your statement a  
41 number of matters relating to who did what, but can I come  
42 to what you say in paragraph 41 of your statement. In  
43 paragraph 41, after you've described the different roles  
44 the different parts of the centre played, you make some  
45 general observations about how most of the Operations staff  
46 were in their dealings with the children?  
47 A. Yes.

- 1  
2 Q. What were the observations that you made about that?  
3 A. Some of the observations that I made about operational  
4 staff and how they would speak to and work with the young  
5 people were that they were highly punitive in their  
6 approaches, very authoritative in the way that they would  
7 speak to them, often verbally abusive, sometimes physically  
8 abusive or excessively forceful. They would belittle them  
9 and humiliate them, name call. It seemed to me that it was  
10 often, and not always, and not all staff, but it was often  
11 their intention to ensure that the young person knew who  
12 was in control and who was, you know, that they had less  
13 power than the grown-up did.  
14  
15 Q. We've heard from other evidence that officially the  
16 approach of Ashley was that it was a place of  
17 rehabilitation and restorative practices that valued and  
18 respected the young people. During your period there, is  
19 that the culture you observed being demonstrated?  
20 A. Not in any way, shape or form.  
21  
22 Q. In particular, did you make an observation about the  
23 attitude towards the kids and the value that Operations  
24 staff placed on the children?  
25 A. Absolutely, yeah. I felt like they held very little  
26 value and didn't respect the children; certainly didn't  
27 have - and again, not all staff, but the majority - I'm  
28 confident in saying that the majority did not look to meet  
29 their needs, did not care about what they could do to best  
30 support individual young people in their rehabilitation,  
31 how they could best support them; that wasn't something  
32 that entered the conversation.  
33  
34 Q. Of course, we're aware from other evidence that the  
35 cohort of children who find themselves in Ashley are for a  
36 variety of reasons very complicated children?  
37 A. Of course, yes.  
38  
39 Q. And at least some of them, if not all, display very  
40 challenging behaviours?  
41 A. M'mm.  
42  
43 Q. Including potentially violent behaviours towards staff  
44 or towards other detainees?  
45 A. That's right.  
46  
47 Q. And so, I take it you would agree that the children

1 would have been sometimes very difficult for staff to work  
2 with?

3 A. Absolutely, it's a very difficult work environment for  
4 everyone. As you say, the children that are detained often  
5 present in a very complex way and, you know, it does  
6 require a high level of skill to be able to work with them  
7 effectively.

8

9 Q. But I gather you would have some reflections on, I  
10 suppose, the children being more than the sum of their  
11 behaviours and the value that the children had beyond that;  
12 what are those reflections?

13 A. My reflections on that would be that, you know, quite  
14 apart from the reasons that they might be in detention,  
15 these were young people who I often had really lovely  
16 interactions with and I saw them be kind to their peers, I  
17 saw them be funny, I saw them have, you know, child-like  
18 interactions and I think it's really important to note and  
19 remember always in that kind of work environment that they  
20 are more than their offending history and there's reasons  
21 that led to their offending. And for the most part I found  
22 that they responded extremely well to any staff that worked  
23 in a gentle or therapeutic way, and a lot of them - yeah,  
24 they're just like any child; they just wanted support and  
25 care.

26

27 Q. From your observation, did at least most of the  
28 children in Ashley want to change and improve their  
29 circumstances?

30 A. Yes, the majority, absolutely.

31

32 Q. You make some observations in your statement, and the  
33 Commission's heard other evidence about this already, about  
34 the system that was used to allocate colours to children  
35 and the way in which the colours system governed how many  
36 privileges children did or didn't have from a given week?

37 A. Yes.

38

39 Q. And you talk about this at paragraph 42 of your  
40 statement. As I understand your evidence, the way in which  
41 a child's colour rating would be determined depended in  
42 part on whether there'd been incidents involving that child  
43 week-to-week; is that right?

44 A. Yep.

45

46 Q. You make some observations in your statement about  
47 concerns you had about the way in which what was or wasn't

1 an incident would be defined and whether or not incidents  
2 would be fairly and appropriately reported. Can you tell  
3 us about the concerns you had about that?

4 A. Yes. I suppose my greatest concern around that was  
5 that there was inconsistency around what people viewed an  
6 incident to be, and also inconsistency around what was  
7 reported and what wasn't. There was - yeah, it was a --

8

9 Q. Can I ask you this: you said there was inconsistency.  
10 What did you observe to be the kinds of reasons that might  
11 lead to someone being written up for an incident or perhaps  
12 not being written up for an incident?

13 A. It was my observations that some of the children who  
14 presented with more difficult behaviours or who might be  
15 more challenging to manage within the centre would be much,  
16 much more likely to be written up than those who were more  
17 compliant or easier to manage, and quite often the details  
18 of the reports that we were seeing, incident reports,  
19 didn't align with what either the young person was saying  
20 or in some cases what we had seen.

21

22 Q. Did you observe in some cases if a child was  
23 well-liked within the centre, they'd get away with things,  
24 to put it very bluntly?

25 A. Yes, to put it bluntly; there were some children that  
26 were blatantly favoured and it was inexplicable to a number  
27 of us as to how they were able to maintain, you know, a  
28 green level given the behaviours that they were exhibiting.

29

30 Q. And, did you see the opposite as well, that children  
31 who were disliked would be much more likely to be punished  
32 and written up for things that their peers might not be?

33 A. Absolutely.

34

35 Q. I think you give a number of examples of that in your  
36 statement, including a child who we're referring to as  
37 "Max"?

38 A. Yep.

39

40 Q. Can you tell us about your observations of the  
41 treatment you saw Max receive as a general practice  
42 compared to some of his peers?

43 A. In general, I suppose, when Max was first admitted  
44 during my time at the centre I was warned in advance that  
45 this person was, you know, highly manipulative and we  
46 needed to sort of - I needed to be eyes wide open about him  
47 because he'll wrap you around his little finger. And he

1 was sort of portrayed as this nasty, sly, sort of child,  
2 and I found that really obviously inappropriate and bizarre  
3 and it certainly wasn't what I found to be true of that  
4 young person. But he was singled out repeatedly and  
5 consistently by staff whenever I was able to observe that;  
6 I don't know why.

7  
8 Q. Because I suppose some staff might say that that's  
9 evidence that he'd succeeded in wrapping you round his  
10 little finger, I suppose --

11 A. Correct.

12  
13 Q. -- and portraying a false view of himself to you; how  
14 would you respond to that suggestion?

15 A. I would respond to that by saying that I would take  
16 each young person at face value and get to know them, you  
17 know, assuming the best, and that he never actually did  
18 anything or showed any behaviours that would lead me to  
19 believe what I had been told was correct, and the things  
20 that he did do that were concerning or questionable, they  
21 were for relatively understandable reasons.

22  
23 Q. The Commission heard some evidence earlier on today  
24 from Ms Gardiner that I don't know if you had a chance to  
25 hear?

26 A. I didn't.

27  
28 Q. But part of her evidence was the extent to which young  
29 people might not be in control of their own behaviour, and  
30 the system operated on the assumption that they were making  
31 rational informed decisions to behave well or behave badly  
32 and were treated accordingly. Was that the attitude that  
33 you observed when you were at Ashley?

34 A. Sorry, could you just repeat that?

35  
36 Q. Yes. Ms Gardiner observed that the approach to a lot  
37 of children at Ashley was, they were treated as if they  
38 were making informed decisions about their behaviour, when  
39 her sense was often these were young people who weren't in  
40 control, and that her observation was that the Behaviour  
41 Management System perhaps punished people - my words, not  
42 hers - for things that children were not doing consciously  
43 or intentionally.

44 A. Absolutely. Due to the - as we discussed, due to the  
45 complex presentation that a lot of these young people had,  
46 various diagnoses that they might have, a lot of them  
47 struggled with impulse control, struggled to regulate their

1 emotions. They were being punished for behaviours that  
2 were outside of their control without us giving them  
3 strategies to help manage those behaviours, and I think  
4 that if we had have been given the opportunity to do that,  
5 a lot of those behaviours would have been reduced and,  
6 therefore, you know, the punishment would have been reduced  
7 and they would have had a much safer, more rehabilitative  
8 experience.

9  
10 Q. One of the other comments that you make in your  
11 statement at paragraph 53 about incident reporting is that  
12 there'd be a lot of - well, variability of quality, I  
13 suppose, of incident reports, and that you came to  
14 understand that that had two causes: firstly, a lot of  
15 staff weren't aware of the policies in place, but secondly,  
16 there was some significant literacy issues as well amongst  
17 the staff?

18 A. Yes.

19  
20 Q. Can you tell us how you came to discover that?

21 A. Well, I suppose that's two things happened: one was  
22 that a staff member disclosed to me that they had literacy  
23 issues and needed assistance in understanding the care  
24 plans that would be produced regarding individual children,  
25 so we put things in place to help that person get the  
26 information in a different way.

27  
28 And the other way that I learnt that was from reading  
29 reports that had been written by staff that were sometimes  
30 quite illegible and made very little sense, were largely  
31 incomplete, they were difficult to understand.

32  
33 Q. And so, what were your reflections then on how well it  
34 was possible for Operations staff to implement policies and  
35 to assess potential incidents against those policies, given  
36 what you'd observed?

37 A. I think, due to a number of factors, it was nearly  
38 impossible or proved to be quite impossible for staff to  
39 accurately and adequately report on incidences as they  
40 occurred in a way that we would consider complete or  
41 appropriate.

42  
43 Q. At paragraph 63 and following of your statement you  
44 deal with the Centre Support Team, and that was the team,  
45 as I understand your evidence, which met every week on a  
46 Monday and which made decisions about what each child in  
47 the centre's colour ranking would be for the coming week.

1 A. Yes.

2

3 Q. As I understand your evidence, in order for an  
4 incident to make it onto the agenda for a child at a CST,  
5 it would have needed to have been reported at a certain  
6 level?

7 A. Yes.

8

9 Q. And so, firstly, that might mean that if things had  
10 been underreported the CST would never find out about them?

11 A. That's right, yes. For the most part.

12

13 Q. Did that sometimes happen in your experience?

14 A. It did emerge that that had happened, and I'm unsure  
15 to the extent that that occurred because we wouldn't know  
16 about them.

17

18 Q. As I understand it, you also say at paragraph 68 that  
19 sometimes things would make it onto the agenda because they  
20 had been assessed at a higher degree of seriousness, but in  
21 fact on investigation they would be downgraded; can you  
22 tell us about that?

23 A. Yeah. Sometimes we would get incident reports that  
24 would come across the table, and as a group there would be,  
25 you know, a discussion, sometimes quite robust ones between  
26 different teams, because it seemed as though a child's  
27 particular needs or, you know, context wasn't always taken  
28 into account, or they weren't - the report wasn't written  
29 in a fully unbiased way; perhaps it was coming from a  
30 particular viewpoint of a staff member who, in a lot of  
31 cases, maybe had a bit of a grudge against a child or  
32 wanted to essentially punish them and used incident  
33 reporting as a way to do so. And often, you know, by  
34 fleshing that out we would establish that the behaviour  
35 that, once we pared it back to what might have caused that  
36 behaviour or what led up to it, what was put in place to  
37 prevent it, et cetera, that the level of seriousness was  
38 often lower than it was recorded to be.

39

40 Q. You've mentioned that - an observation that in many  
41 cases perhaps incident reports had been written in a way  
42 perhaps designed to punish a child, and I think it would be  
43 fair to say that your experience was that the CST process  
44 more generally operated in quite a punitive way; would you  
45 agree with that?

46 A. Yes, absolutely.

47

1 Q. And, as I'm sure you're aware, the Commission's asked  
2 for evidence from a number of other people, including a  
3 number of other staff members who would have attended those  
4 meetings from time to time, and it would be fair to say  
5 that whilst some of them agree with you, there are a number  
6 of people who have given statements to the Commission  
7 saying that in their experience the CST always operated in  
8 a very fair and unbiased manner, and I wanted to tell you  
9 that and ask you for your reflection in light of it?

10 A. I vehemently disagree with that. I did not attend a  
11 single CST meeting in my time at the centre that was  
12 professional, organised, appropriate. It didn't occur.  
13

14 Q. One of the particular things you identify in your  
15 statement at paragraph 72 onwards is the way in which the  
16 outcomes of the CST meetings would be conveyed to children?

17 A. Yep.  
18

19 Q. The ranking for each child would have been determined  
20 in that meeting. Can you tell us then the process that you  
21 observed by which children would be told what their ranking  
22 for the coming week would be?

23 A. Yeah. So, because obviously there's a lot of children  
24 and a lot of discussion, CST meeting typically took all  
25 morning. The centre would then be locked down for a period  
26 of one to two hours sometimes, and essentially the CST team  
27 goes from unit to unit and enters each child's cell to  
28 deliver them their colour rating that we had established  
29 for the week, for the week ahead based on the week that had  
30 passed. And depending who was in attendance at the CST, I  
31 would say there was often between four to seven adults in a  
32 child's cell, and the child had to sit on their bed and be  
33 still while these adults delivered what was often not nice  
34 news; it was often disappointing news, and it wasn't always  
35 delivered - well, it was very rarely delivered in a  
36 therapeutic or supportive way. I found it mortifying to  
37 watch, and I think that for the young people, you know,  
38 once we had delivered that result, and it was delivered  
39 usually by a youth worker or - not some of the therapeutic  
40 staff, it would end with us leaving and locking the cell  
41 and moving onto the next cell until --  
42

43 PRESIDENT NEAVE: Q. So you were part of those meetings?

44 A. Yes.  
45

46 Q. So you walked around with --

47 A. Absolutely.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. -- some of the youth workers and the other members of the committee, and the whole committee delivered the news to the child, that, "You're going up from green to orange," or something?

A. Correct.

COMMISSIONER BROMFIELD: Q. I noticed you used the word "disappointing", which is a fairly adult word. What were some of the reactions like? And these were big things, I take it, the colour ratings for kids in the centre?

A. Yeah. Yeah, absolutely. It defines what their next week is going to look like. And for young people, that's very big. It could be the difference between calling home a few more times than you might be able to otherwise, or having chips on a Friday night, or a movie. You know, that's all the things that they look forward to, so it is a big deal. And yes, some of the responses would be, you know, that people would be upset, they would be visibly distressed, sometimes they would be quite withdrawn and just say you know, "Get out. I want to be by myself", or whatever it might be. Sometimes there was extreme - well, from a low level of anger to quite high levels of anger where they would be furious that this had occurred and they wouldn't understand.

What I found particularly difficult, being in that room, was that we didn't have the opportunity to sit and explain to them what had happened or get their thoughts and reflections on their week and, most importantly, where to from here. You know, I felt that was a really big missed opportunity to not use that platform to talk about how we could move forward, you know, in a different way.

Q. And so, I guess I'm drawing this out more for the benefit of the live stream.

A. Sure.

Q. So when you say you then had to close the door and walk away, and that that was hard, it was because you were leaving children who were crying or angry or feeling that it was unjust; so, really significant?

A. Some of the children were absolutely devastated, like, you know, some of them were on or would soon be put on SASH as a result of, you know, bad news; some of them, or quite a lot of them, had mental health issues as it was. It was devastating. And absolutely, locking the door behind you

1 and leaving them in that state without so much as an  
2 explanation or a plan felt - yeah, it was awful.

3  
4 MS ELLYARD: Q. At paragraphs 74 and 75 of your  
5 statement, Alysha, you give a couple of particular examples  
6 of behaviour that you observed from Operations staff. Can  
7 I draw your attention, firstly, to paragraph 74. Can you  
8 tell us about that occasion?

9 A. Yes. On that occasion we were all walking across to  
10 that particular unit. We went to deliver the CST results  
11 to one young person, called Richard, who had a diagnosis of  
12 ADHD and did struggle with impulse control. He was  
13 considered quite a complex, high-needs child, and when the  
14 person - his name was "Lester" - was delivering the results  
15 to this young person, he said if he continued behaving the  
16 way that he had, he would turn his face into an owl.

17  
18 Q. And, what did you understand come to understand later  
19 on that reference to "turning his face into an owl" meant?

20 A. Well, at the time I had no idea. It was back in the  
21 courtyard when I said, "What did that mean?", and he  
22 laughed and said, "It meant he'd cave the child's face in  
23 so it was concave like an owl".

24  
25 Q. On another occasion, you describe in paragraph 75 of  
26 your statement making an attempt to approach the child and  
27 the news being delivered in a more therapeutic way by  
28 sitting on the child's bed. When you did that, what was  
29 said to you by one of your colleagues?

30 A. I just preface this with the fact that I would  
31 typically never sit on a child's bed, but they sat - or  
32 this child in particular was sitting on their pillow, and I  
33 sort of perched on the very foot of the bed so that one  
34 person in the room could be at eye level with the child,  
35 and one of the other workers in the room said in a joking  
36 manner, that - "Look out." It was something to the effect  
37 of, "Watch out, you'll probably catch something from him if  
38 you sit there."

39  
40 Q. And did you see the child's reaction to that being  
41 said?

42 A. Yes, he was so crushed and humiliated. It was - I  
43 felt, very sad.

44  
45 Q. And so, this would all happen on a Monday morning each  
46 week?

47 A. Every Monday.

1  
2 Q. What would be the effect overall on the centre and its  
3 smooth operations from this process that you've described  
4 of individual children --

5  
6 PRESIDENT NEAVE: I'm sorry, we've just lost sound,  
7 I believe. Do we need to adjourn briefly?

8  
9 MS ELLYARD: We're about to take the lunch break. Is it  
10 convenient if we do that and resume after lunch?

11  
12 PRESIDENT NEAVE: We could do that? Yes, all right.  
13 Well, we will.

14  
15 MS ELLYARD: If the Commission pleases, we'll pause there  
16 for lunch.

17  
18 **LUNCHEON ADJOURNMENT**

19  
20 PRESIDENT NEAVE: Before we start, Ms Ellyard, our  
21 witness, Erin, gave evidence under the name of Erin, it was  
22 a discussion during the time that she was giving her  
23 evidence relating to some matters that she did not want to  
24 have identified in relation to incidents; they related to  
25 matters relating to the location at the Ashley Youth  
26 Detention Centre at which matters occurred and the date and  
27 time, the specific date and time at which those incidents  
28 occurred. I will make those orders. The orders will be  
29 posted on the outside of the hearing room and anybody who  
30 needs information as to what they can and can't say should  
31 contact our media officer.

32  
33 MS ELLYARD: Thank you, Commissioner.

34  
35 Q. Alysha, before the break we were talking about the CST  
36 and your observations about the way it worked. The  
37 Commission's also heard from a number of other witnesses  
38 about the MDT, which you also describe in your statement.  
39 Some of the evidence that we've heard so far suggests that  
40 people have the experience that the recommendations of the  
41 Multi-Disciplinary Team were often disregarded or not given  
42 appropriate weight by Operations staff. Was that your  
43 experience?

44 A. Yeah, it was, definitely.

45  
46 Q. And just to be clear, the particular role of the MDT  
47 was to make recommendations based on the therapeutic and

1 other needs of the young people?

2 A. Yeah, it was to really do a deep dive into an  
3 individual's needs and create, like, an individualised care  
4 plan.

5

6 Q. And that might include such things as, this young  
7 person is vulnerable in particular ways which should be  
8 taken into account in making decisions about where they're  
9 placed in the centre?

10 A. Yeah, we might make recommendations about where they  
11 should be housed or who they might do well with being  
12 around, what sort of strategies we could use to help them  
13 manage their emotions and regulate; all kinds of things of  
14 what's working and what's not and, you know, what we can do  
15 better.

16

17 Q. Some of the statements that the Commission has  
18 received from staff at the centre who perhaps worked more  
19 in the Operations side suggest that there was a view on  
20 behalf of some of those Operations staff that perhaps the  
21 MDT didn't perhaps operational reality and would make  
22 recommendations that were just not achievable. Were you  
23 familiar with that sentiment being expressed?

24 A. Yes, I had sort of a unique position, I suppose, where  
25 I think I was perhaps the only staff member that sat weekly  
26 on both meetings', both the CST, which is predominantly  
27 operational focused, and the MDT meeting which is more  
28 about the professional therapeutic focus. So, I got to  
29 hear both sides of that, you know, of the therapeutic staff  
30 feeling like, you know, our recommendations often weren't  
31 maybe listened to or adhered to or implemented or - and  
32 certainly the operational staff feeling like the things  
33 that came out of MDT were unreasonable or not workable in  
34 the way that they operated, so there was an absolute  
35 disconnect between the two groups and it was difficult to  
36 be the go-between at times.

37

38 Q. From your perspective of someone who sat across two  
39 groups though, do you have a view on who was right? Is it  
40 both and/or is it either/or? Was it the case that the MDT  
41 recommendations lacked reality or were not operationalised?

42 A. They weren't implemented. They could have been given  
43 the right support, implementation and thought, I think, but  
44 they certainly weren't possible as things were.

45

46 Q. Would it be fair to say that in part they weren't  
47 possible because there wasn't necessarily the skillset and

1 the staffing resources in the Operations side of things to  
2 be able to give practical effect to what the MDT  
3 recommended?

4 A. I would agree with that. On top of that there was a  
5 lack of willingness in a lot of cases to change or think  
6 about changing the way that they were working to consider  
7 new approaches; it wasn't something that a lot of staff  
8 were open to considering so, without that, there's very  
9 little you can do, you know.

10  
11 Q. I understand. Can I turn to ask you then some  
12 questions about isolation which you deal with at  
13 paragraph 90 and following of your statement. You make the  
14 point in your statement that in your experience and  
15 observation at Ashley there were two kinds of isolation:  
16 there was isolation as we heard about from Ms Honan on  
17 Friday as a legal concept which had quite strict  
18 requirements around it about who could authorise it and for  
19 how long, but there's also another category of what you've  
20 called, it's your term, subversive isolation. Can you tell  
21 us what was that?

22 A. It seemed to come in in a few different forms, I  
23 suppose. Sometimes different terms were used to do what I  
24 would consider or would be what I would consider isolation.  
25 So, I'd hear terms be thrown around like "kids being unit  
26 bound" or "kids being on a Blue Program" or "we'll put that  
27 child on blue", or you know, that sort of - and what I came  
28 to understand those things to mean was that they were  
29 variations of different kinds of isolation that didn't  
30 follow the legal or the, you know, the typical processes  
31 that we would need to if we were going to isolate children  
32 appropriately and legally.

33  
34 Q. At paragraph 96 and following of your statement you  
35 give an example of the use of unit bound practices, and  
36 that was the aftermath of a roof incident on 13 December  
37 where three young people, who we're calling Elijah, Joseph  
38 and Arlo, had been on the roof and they came down and they  
39 were unit bound over at least, according to the records,  
40 four days and potentially from your recollection much  
41 longer.

42  
43 I'm drawing you attention to paragraph 97 of your  
44 statement. Can you tell us about the discussion that was  
45 had at the CST meeting on Monday morning when staff  
46 gathered to learn that children had been "unit bound" over  
47 the three or four days prior?

1 A. Yes, there was quite a robust conversation that took  
2 place between some of the Professional Team and the  
3 Operational staff. The children were still isolated at  
4 that point and we were - "we" being the Professional Team  
5 members - were making the case that, to justify isolating a  
6 child we need to be able to demonstrate that there's a  
7 current and present risk, that they are still making  
8 threats or that they're at risk of harm to themselves or  
9 others. That wasn't the case. These kids were - I can't  
10 be certain if it was all three, but certainly I think it  
11 was, there was remorse; at least a couple of them knew that  
12 what they had done was wrong and they were apologetic.  
13 There was certainly no risk and nothing that would justify  
14 legal isolation of them at that stage, and the operational  
15 staff didn't seem to - that didn't matter to them; it was  
16 about punishment; it was that, "But they need to learn that  
17 rioting is wrong and therefore they must be isolated".  
18

19 There was a gap, I suppose, in knowledge about what  
20 our role was and that, you know, it was not our role to  
21 punish children, it was our role to support them and that  
22 was a consistent area of, you know, difficult  
23 conversations, I suppose.  
24

25 Q. At paragraph 98 of your statement you describe a  
26 conversation that you had with Hugh, one of the operational  
27 staff members, about the documentation or the processes  
28 that had been followed. Can you tell us about that?

29 A. Yes. So, I worked Monday through Friday, so the  
30 incident was on the Friday, I came to work on the Monday,  
31 we had our CST and this worker, Hugh, said "Oh, you know",  
32 I said, "How was the weekend?" He said, "I've got this  
33 program that we set up basically", he was very proud of it,  
34 he was quite impressed, and I was impressed also to - it  
35 was more than I had seen an operational ops coordinator do  
36 so far. He had made an effort to make sure that there were  
37 more activities and things that were available to the  
38 children that had been isolated over the weekend, but it  
39 was still isolation.  
40

41 Q. So, this is a document I think the Commission has seen  
42 that shows for each child hourly units of time?

43 A. Yes.  
44

45 Q. Cards in room, TV time, chatting?

46 A. Yes.  
47

1 Q. But the net effect of it still was that the children  
2 were in their room or at least in their the unit the whole  
3 time?

4 A. Yes, absolutely. So, whilst I was - you know, it was  
5 impressive, that was a good example of work that I had seen  
6 so far from the standard we were working with. However, it  
7 was just a different way to justify isolating children that  
8 didn't pose a risk.

9

10 Q. A bit more thought into what the children would do,  
11 but not grappling with the real issue was, they didn't pose  
12 a risk, they shouldn't have been in isolation?

13 A. Yeah, there was no legal reason to justify, yep.

14

15 Q. Can I ask you now some questions about searching. The  
16 Commission's heard evidence from a number of lived  
17 experience witnesses, including the witness we heard from  
18 today, about their experiences of being searched. At  
19 paragraph 114 and following, you talk a bit about  
20 strip-searching, and at paragraph 120 in particular, you  
21 refer to what seemed to you to be the variable practices in  
22 relation to the use of searches; can you tell us about  
23 that?

24 A. Sorry, I'll just familiarise myself with this part of  
25 my statement.

26

27 Q. So I'm drawing your attention in particular to  
28 paragraph 120 and following.

29 A. Yeah, okay. Again, it was mostly - that part of my  
30 statement is mostly about the inconsistency in which  
31 searches were applied. They seemed to take place more  
32 regularly when there were smaller younger children involved  
33 or children that were less liked within the centre, and  
34 there were certainly some kids that were just never  
35 searched.

36

37 Q. You give an example at paragraph 123 of an occasion  
38 where perhaps it be more likely to be said that a search  
39 was justified but in that case it didn't occur: tell us  
40 about that?

41 A. Yeah. Well, I personally don't think that personal  
42 searches are easily justified at all. I'll preface what  
43 I'm saying with that, but there was one instance where it  
44 appeared that contraband and drugs had come into the  
45 centre, or that was the suspicion that we had. That, out  
46 of all my time at the centre would have reasonably  
47 justified searching a child, and that didn't occur. So,

1 you know, when searching was occurring to maybe first-time  
2 residents at Ashley who are really young and really small,  
3 vulnerable, scared, and they were being strip-searched and  
4 then there was instances like that, and they weren't, that  
5 was very difficult to reconcile.  
6

7 Q. And to be clear, as you say in your statement, the  
8 child who perhaps could have been searched, assuming  
9 searches are legitimate, was an older and well-liked - it  
10 was Finn who we've heard about in other contexts?

11 A. He was extremely well looked after.  
12

13 Q. Can I come then to the question briefly of Finn and  
14 Albert and the Commission has heard some evidence already  
15 from a couple of witnesses about some of the behaviours  
16 that Finn and Albert displayed and the extent to which  
17 those behaviours were appropriately managed.  
18

19 The Commission is aware that one young boy who we're  
20 calling Henry was sexually assaulted, it would seem, in the  
21 unit by Finn and Albert. But as you make it clear in your  
22 statement at about paragraph 168, in fact that incident and  
23 another incident in the days before, I think, involved a  
24 second young person who we're calling Jonathan?

25 A. Correct.  
26

27 Q. Can you tell us what you came to understand had  
28 happened to Jonathan in the context of Finn and Albert?

29 A. I'm not entirely familiar with what happened to  
30 Jonathan in the days preceding what happened to --  
31

32 Q. Henry.

33 A. -- Henry, thank you, so many pseudonyms. I just know  
34 that there were was a series of incidents and the incident  
35 that occurred regarding Jonathan was involving a third  
36 older, bigger resident as well as Finn and Albert, and that  
37 Jonathan was present for the assault on Henry.  
38

39 Q. And so, although there was subsequently a very  
40 detailed review conducted into all of the circumstances of  
41 the assault on Henry, you came to understand that that  
42 assault, as awful as it was, was in fact part of a series  
43 of behaviours and experiences that children in the Franklin  
44 Unit were being exposed to?

45 A. Absolutely, and even if we just look at that specific  
46 timeframe, I believe that within a two or three day period  
47 there was six to seven assaults of some kind on those young



1 people and I don't know - I still don't know the full  
2 details of them. I was only able to incidentally access  
3 reports regarding the significant assault against Henry  
4 with Jonathan there.

5  
6 Q. And to be clear, these were things that you came to  
7 learn of later, they had taken place at a time prior to you  
8 starting your work at Ashley?

9 A. Absolutely, yeah.

10  
11 Q. In the context of what you came to learn in  
12 around November 2019, as you say in your statement, of the  
13 assault on Henry there was a review commissioned by the  
14 Seriously Events Review Team and, at paragraphs 178 and 179  
15 of your statement you describe some experiences you had on  
16 12 February 2020 when members of the SERT Team came to the  
17 centre as part of their investigation; can you tell us what  
18 happened on that day?

19 A. Yes, so they came to the centre, I believe with the  
20 intention to interview relevant staff members and also  
21 gather some documentation or whatever it is they needed to  
22 conduct their investigation. I had been tasked by Pam, my  
23 Director, with making whatever they needed available to  
24 them, so I was trying to accommodate that.

25  
26 At a certain point of the day the SERT investigators  
27 required files from a, what had become a locked cabinet,  
28 which is the cabinet which held the paper files of all the  
29 children's incident reports. So, the person who had the  
30 keys to that cabinet at this point was Lester. So, I got  
31 the keys from him and explained that I needed to provide  
32 some things to the SERT investigators, and he was quite  
33 reluctant to allow that to happen. I said, "Look, I've  
34 been directed to do that, we need to give them what they  
35 require". He very begrudgingly came and unlocked it for  
36 me. The SERT investigators were with us in the room also,  
37 and he said that he didn't think the files that we were  
38 looking for were available, and I said, "Let's have a  
39 look", because the children were current residents so, you  
40 know. But he did say that, "No, he thinks they have been  
41 archived", and it was a very - why would they be archived,  
42 they're currently here? It's a bit odd. And in fact I was  
43 able to, because they had their names on the side of the  
44 lever arch file, I was able to see one of the files and  
45 say, "There's one of them", and he essentially refused to  
46 give them to the investigators and they were very gracious  
47 and just said that they would take that back to the

1 Director, that Lester was unwilling to provide those  
2 documents to them.

3  
4 Q. Thank you. I want to move to a different topic now  
5 and I'm drawing your attention to --

6  
7 PRESIDENT NEAVE: Q. Sorry, I did have one question.  
8 You've talked quite a bit about Finn and Albert and the  
9 fact that they were well-liked and perhaps treated more  
10 liberally than some of the more children and young people.  
11 Given that they had been violent in various different ways,  
12 perhaps, I'm not sure, but perhaps only against other  
13 children: why do you think that they were treated  
14 favourably? Was there a reason for that?

15 A. There is what came to be, I suppose, a broadly held  
16 belief that they were - because of their consistent green,  
17 you know, colour rating under that BDS, despite these  
18 pretty consistent regular, violent or sexual assaults on  
19 other residents, that the staff may have been, I suppose,  
20 utilising them to help manage the behaviour of the smaller  
21 more vulnerable children in the centre.

22  
23 Q. So, they were rated green and you say that that was  
24 favouritism, I think, or may have been favouritism?

25 A. Well, certainly - yes, if another child outside of  
26 those two - and from what I understand historically there's  
27 always been sort of kids that are representative of those  
28 two, it's not just a - you know, there's always a few that  
29 I understand are typically in the Franklin Unit, you know,  
30 bigger older boys who might be treated differently to the  
31 other children and given extra privileges. Certainly, if  
32 any of the assaults that those two individuals carried out  
33 were carried out by other residents, that would result in a  
34 DO, which is the highest level of --

35  
36 Q. Yes.

37 A. -- and that was what we expected to happen for them as  
38 well. It never happened, and in fact when we pushed back a  
39 little bit and sort of questioned that and said, "Why are  
40 we not applying this consistently?", it became quite - the  
41 staff became extremely aggressive and angry at the prospect  
42 that those children should be anything but green. You  
43 know, we have done quite thorough risk assessments, there  
44 is one in my statement --

45  
46 Q. M'hmm.

47 A. -- yep, and yet they were the most violent offenders

1 in the centre. They were also the only two that were  
2 allowed off-site in my time there and that, to me, is  
3 very - it raises a lot of questions obviously about  
4 consistency and about fairness, but also why was that  
5 happening, and I believe it may have been, or at least my  
6 best assumption having watched it unfold repeatedly, is  
7 that they were used to - you know, they were scary and, if  
8 the young children knew that they were in Franklin and they  
9 were potentially going to be at risk of harm from these  
10 older boys, that they would behave better to avoid going  
11 there.

12  
13 Q. I just want to test that a little bit, because another  
14 approach of the operational staff could be to say these  
15 older boys were more difficult to contain, their behaviour  
16 is more troubling.

17 A. Yep.

18  
19 Q. And we will therefore apply more rigorous policies  
20 against them, we'll give them higher ratings on the  
21 Behaviour Development Program and so on, and yet, that  
22 wasn't so. So, your explanation of that was that they were  
23 sort of de facto managers of the younger children?

24 A. I have witnessed those children dictate who works in  
25 their unit, what other children are moved into and out of  
26 their unit. The staff often did what those boys said.

27  
28 Q. So, the staff deferred to these - were the staff  
29 frightened of them? Was that an issue?

30 A. I'm not sure. Perhaps some might have been, but  
31 certainly not all of them. They seemed to be - there was a  
32 very tight-knit relationship between what was referred to  
33 as Franklin residents and Franklin staff; it's, those  
34 people didn't rotate through, they were Franklin staff, and  
35 they defended each other very much.

36  
37 To me and my constant recommendations were just to  
38 sort of get a better understanding of what was happening,  
39 was to rotate the staff through the units and put some  
40 other staff in that unit and see if they had --

41  
42 Q. What happened?

43 A. Yeah, what happened, if there was any different  
44 outcomes that they might report or if there was different  
45 behaviours that we might see coming up in CST that other  
46 staff viewed as not green behaviours. That, unfortunately,  
47 didn't take place, but it certainly would have been

1 interesting to see.

2

3 Q. So, it was the same group of staff who worked in  
4 Franklin, Operational staff?

5 A. Franklin staff, yep.

6

7 Q. And the same group of boys who tended to be in  
8 Franklin?

9 A. Yeah, absolutely, and if there was - on numerous  
10 occasions, and this is noted in meeting minutes and things,  
11 that if a specific child was transferred to their unit, the  
12 bigger boys' unit, that they didn't like, they would get  
13 them moved; the staff would get them moved for the boys.

14

15 PRESIDENT NEAVE: Thank you.

16

17 MS ELLYARD: Q. There's some suggestion in the minutes  
18 of CST meetings that paragraphs the view was being taken by  
19 some Operations staff that Albert and Finn were potential  
20 leaders and that opportunities should be given to them to  
21 exercise a leadership role as part of, I suppose, one would  
22 say, skilling them up for kind of in pro-social ways to  
23 operate outside of Ashley. Are you familiar with that?

24 A. That way of thinking about those?

25

26 Q. Yeah?

27 A. Yeah, I have heard that. I struggle with that logic  
28 because the evidence of their assaultative behaviour is  
29 very clear, that they are some of the most violent  
30 offenders there, that they were not - you know, they  
31 weren't displaying characteristics we'd like to see as  
32 leaders. But also, we worked really hard at devising a  
33 program to try and help them address some of their problem  
34 offending behaviours within the centre and we were not  
35 allowed to do that work. So, if indeed they were - if we  
36 even accepted that we wanted to build them up to be  
37 leaders, that was obstructed anyway, so I can't understand  
38 that way of thinking.

39

40 COMMISSIONER BROMFIELD: Q. Based on the interactions  
41 that you'd had with residents, some of the other boys, I  
42 gathered from your statement that the other detainees were  
43 characterising it more as fear-based behaviour management?

44 A. Yes.

45

46 Q. I know you spoke earlier about the strip-searches, so  
47 I get the - so, fear-based behaviour management being one

1 possible reason. You also made a comment in your statement  
2 that one of the reasons for the strip-searching with the  
3 younger boys that was given to you was about breaking them  
4 down. Could you just expand on that a bit?

5 A. I can't expand on it too much other than, that was all  
6 that was said to me and it was said in the context of, it  
7 was actually a bit of a joke, "It's a part of breaking them  
8 in", like, "Welcome to Ashley" sort of way of - yep, like  
9 an initiation or something to get them used to this tough  
10 new sort of environment: that's how I interpreted that.

11  
12 Q. And, was your observation of, you know, the fear-based  
13 placement practices and the breaking them in type practices  
14 part of - because it was directed at the younger detainees,  
15 was that about, I guess, setting up for them their  
16 expectations of Ashley and how they wanted the detainees  
17 to, I guess, understand how the place worked and who was in  
18 control?

19 A. Yeah, that's absolutely my belief and what I saw  
20 unfolding that, you know, we would - it would be very  
21 uncommon, for example, for a young person to come to Ashley  
22 once and not come back; usually it's, as you know, they're  
23 repeat visitors, and I think that they wanted to instil  
24 those lessons nice and early to make sure that they were  
25 well managed or more easily managed as time went on and to  
26 teach them, you know, the way it works at Ashley. I think  
27 that unfortunately there was also an element of wanting to  
28 feel powerful and make the children feel disempowered, and  
29 that played into that process also from what I observed.

30  
31 COMMISSIONER BROMFIELD: Thank you.

32  
33 COMMISSIONER BENJAMIN: Q. If I remember reading your  
34 statement carefully enough, you said on a number of  
35 occasions, "Young people expressed fear of going into  
36 Franklin".

37 A. Yes.

38  
39 Q. And the implication of your evidence is that Franklin  
40 is used, and has been used for some time, as a discipline  
41 or a behavioural device. I also recall reading somewhere  
42 that Ashley can hold up to 42 children or 40-odd children.

43 A. Yes, that's right.

44  
45 Q. And I think in recent years it's been holding between  
46 seven and 15 people; it fluctuates?

47 A. Yes. At the height of the busiest it ever got during

1 my time there was about 20, and that was very brief.

2

3 Q. So, that reflects the use of less than half the  
4 facilities?

5 A. M'mm.

6

7 Q. So, even if cells are damaged or unavailable, and I'm  
8 sorry if I'm using "the cells" not being there, and I think  
9 from my observation that's probably a better description.

10 A. That is most appropriate.

11

12 Q. But there must be other places where the children or  
13 the young people can be safely placed apart from sending  
14 them to Franklin?

15 A. Absolutely. For nearly the entire duration of my six  
16 and a bit months there, there was an entirely empty unit.  
17 The Liffey Unit was not opened unless there was a female  
18 resident for a period of time, and in one case one person  
19 who was going through a detox process, otherwise it was  
20 just not utilised, and that was explained to me as due to  
21 staff shortages.

22

23 Q. So, are all of the units generally full?

24 A. No.

25

26 Q. So, and again, someone might say, well look, if we'd  
27 put them into this unused complex or division --

28 A. Unit, yep.

29

30 Q. -- we don't have the staff to do it. But how do you  
31 see it in relation to the existing facilities that were  
32 properly staffed or adequately staffed?

33 A. I'm so sorry: are you suggesting, if they were  
34 adequately staffed?

35

36 Q. Instead of opening up a new part, were you able to  
37 observe whether there would have been space in the existing  
38 facilities to fit them in by moving from one room to  
39 another?

40 A. Yes, I think there would have been ways to safely and  
41 carefully decide where young people were with the units  
42 that were operational at those times.

43

44 Q. Because my recollection of being there was, there was  
45 a central room and then you had --

46 A. Wings.

47

1 Q. -- rooms or wings off each of those?

2 A. Correct.

3

4 Q. Which had, I think, rooms on one or both sides? I  
5 can't remember?

6 A. Both sides in most units, yeah.

7

8 Q. Thank you.

9 A. So, yeah, there was actually ways to, depending on the  
10 different units, to keep children in, as you say, in one  
11 wing fully separate from the other wing. There was  
12 definitely ways to ensure greater levels of safety.

13

14 COMMISSIONER BENJAMIN: Thank you.

15

16 MS ELLYARD: Q. Alysha, in your statement you give a  
17 number of examples of children coming to harm because of  
18 where they were placed?

19 A. Yes.

20

21 Q. And the way in which staff responded to suggestions  
22 that they were inappropriately placed, and we can't look at  
23 all of them in detail, but I want to ask you some questions  
24 about Ray, and you deal with him at a couple of spots, but  
25 can I direct your attention to paragraph 215 in your  
26 statement because it's an incident involving Ray, Albert  
27 and Finn.

28

29 And as I understand the backstory, there had been  
30 recommendations made although they hadn't been given  
31 effect, that other people not be placed in the Franklin  
32 unit with Albert and Finn, but notwithstanding that, and  
33 for a variety of reasons that have been detailed, children  
34 were placed there including Ray?

35 A. Yes.

36

37 Q. And what ended up happening was, there was what was  
38 subsequently described as a fight in which they were all  
39 equal participants in which Ray was subjected to quite a  
40 significant beating; is that right?

41 A. Yes. I will say that not only were children in  
42 general, there was a recommendation that no children be  
43 placed with those two boys until they received appropriate  
44 intervention, but there was also a specific note to file  
45 regarding Ray, that he ought to never be put in that unit  
46 because of his own complexities and vulnerabilities, so  
47 that was sort of a double - a doubly strange decision. He

1 was placed in that unit and, yes, there was a - what was  
2 described as a fight. I have - that's one of the incidents  
3 that I've seen the footage of and obviously been engaged in  
4 a lot of conversations around: it was, I can say, the most  
5 vicious assault that I saw during my time and there are -  
6 you know, there's a lot of assaults, I'm not gonna lie, but  
7 this was the worst.

8  
9 Q. As I understand your statement, you say the CCTV  
10 footage shows Ray effectively being riled up by the other  
11 two boys; he then throws the first punch, but there's then  
12 a very sustained attack on him in the presence of workers?

13 A. Yeah. What happened - am I allowed to disclose his  
14 diagnosis or perhaps not?

15  
16 Q. I think that's all right?

17 A. Okay.

18  
19 COMMISSIONER BROMFIELD: Q. I think from memory it's a  
20 very common diagnosis for kids at the centre?

21 A. It is. So, Ray had a number of mental health issues  
22 but one of his diagnoses was [REDACTED], and the boys,  
23 particularly Albert and Finn, found it quite amusing  
24 sometimes to sort of play sort of cruel games with his  
25 head, essentially, and trick him and that sort of thing.  
26 And, they were riling him up, that's how I've worded that.  
27 He has additionally very, very limited impulse control. He  
28 did throw a punch at one of the boys and what followed  
29 was - and I didn't time it, but I think we estimated it to  
30 be a 2 to 3 minute period of time where both of these boys  
31 were kicking and punching him to the head and three staff  
32 were present --

33  
34 Q. You can see in the CCTV that they were present?

35 A. You can see the staff, yeah. One of them was a longer  
36 term staffer, there was two other that were a bit newer:  
37 they stood back and allowed it to sort of play itself out.  
38 The child, Ray, I believe, was held back from school due to  
39 a concussion; he was bleeding, he was - you know, it was a  
40 very, very - I can't stress enough how vicious it was, it  
41 was distressing to watch. Yeah, so that happened and it  
42 was reported as a fight.

43  
44 Q. You've made the point in your statement that  
45 ultimately all three children received the same outcome  
46 when the incident was considered by the CST?

47 A. Yes, they did.



1  
2 Q. There were comments made, and I'm referring to  
3 paragraphs 225 and 226 of your statement, I think when  
4 you're reflecting on the way in which different Operations  
5 staff viewed it; the comments that were placed against each  
6 of the children's records for that week, what was put  
7 against Ray's? This is paragraph 225.

8 A. 225, I think from memory - ah, yeah, I think from  
9 memory Ray's always apologetic after incidents, he was  
10 always remorseful, which was really sad for me to see  
11 because he - you know, if you look at that incident in its  
12 entirety, he was the victim of a very serious assault.  
13

14 Q. He had nothing to apologise for?

15 A. He didn't, and he did not receive medical care, he was  
16 concussed, you know, he didn't go to school due to a  
17 concussion, and I guess what concerned me a great deal and  
18 other staff also, was that it bore some similarities to the  
19 death in custody that occurred some years ago and we  
20 weren't sure why we weren't learning from that, why we  
21 weren't instantly seeking medical help for someone who had  
22 sustained a very serious - well, a series of head injuries.  
23

24 Q. Another child who you talk about is Richard, and at --  
25

26 COMMISSIONER BROMFIELD: Sorry, Ms Ellyard.  
27

28 MS ELLYARD: Commissioner.  
29

30 COMMISSIONER BROMFIELD: Q. What were the comments in  
31 the sheet for the other two children?

32 A. That's a really good question.  
33

34 MS ELLYARD: 226.

35 A. Thank you so much. They were copy and pasted for both  
36 those two residents, and it was:  
37

38 *Finn or Albert has had a great week aside*  
39 *from one incident that let him down.*  
40

41 COMMISSIONER BROMFIELD: Thank you.  
42

43 MS ELLYARD: Q. So thinking about Richard who was  
44 another young person who you saw a few times, I think, and  
45 you describe him in your statement at paragraphs 234 and  
46 235, that Richard was very young, he was 14, and he wasn't  
47 violent and didn't have substance abuse issues, and that he

1 had a lot of insight into what he needed. And, you've got  
2 a particular anecdote I think you can tell of him being  
3 able to say what he needed and of you trying to help him  
4 with that?

5 A. Yes. He was a really good example of someone who had  
6 really great prospects; he was young when he came into the  
7 centre, he wasn't using heavy illicit drugs at that time,  
8 he was insightful, intelligent. He was able to say to us  
9 that, or in this instance to me, that, if we could play  
10 basketball for, you know, 10 minutes or so in the morning  
11 or in the day, that helped him a lot, it helped him get  
12 through his school day. He had ADHD and that was one of  
13 the things that helped him cope and he identified that  
14 himself. He said that in the past some workers had done  
15 that and it had worked really well, but that the current  
16 workers weren't prepared to do that. Would I do that with  
17 him? And I was happy to do that, it was 10 minutes of my  
18 day. So, I did play basketball quite badly with him, but  
19 you know, it went a long way and it helped. I,  
20 unfortunately, was unable to continue doing that --

21

22 Q. And that's because Patrick Ryan told you to stop doing  
23 it?

24 A. Yes.

25

26 Q. And what reason did he give you for why you should  
27 stop doing it?

28 A. It's not the scope of my role.

29

30 Q. And whose role could it have been within the scope of,  
31 to help a child with ADHD calm his body for school?

32 A. It's the youth worker's role and I had put it to the  
33 staff in his unit that that would be extremely helpful to  
34 him: it just wasn't happening.

35

36 Q. You go on in your statement in relation to Richard to  
37 say that he too was the subject of a specific notation that  
38 he not be in the Franklin Unit?

39 A. Yes.

40

41 Q. But nevertheless he was placed there, and that over  
42 the course of your time at Ashley you observed a change in  
43 his behaviour after he had been placed in Franklin. Can  
44 you tell us about that?

45 A. Yeah, absolutely. To place a child who is 14 years  
46 old in the Franklin Unit in itself is an inexplicable  
47 decision, but he was placed there. There was concerns

1 noted as time went on that - and this was over multiple  
2 admissions of this young person - that his behaviour was  
3 changing quite a lot. His behaviour became more and more  
4 sexualised, he started making, you know, hypersexual  
5 remarks and saying really crass or crude things to staff  
6 members that were - it was really unusual for him; it was a  
7 new behaviour that ought to have been examined a little  
8 bit.

9  
10 Q. Thank you. Can I turn then to Philip, another young  
11 person who you deal with in your statement at  
12 paragraphs 247 and following. Philip was another child  
13 with a very complex presentation, limited impulse control  
14 and so forth, and in fact in his case that derived at least  
15 in part from the fact that he had an [REDACTED]?

16 A. Absolutely.

17  
18 Q. And you describe in your statement that not always  
19 being well understood by staff because they didn't read  
20 notes or notes weren't available to help him understand  
21 that part of his presentation?

22 A. Yes.

23  
24 Q. You describe in your statement Philip being moved into  
25 the Franklin Unit and his reaction once he was there. I'm  
26 drawing your attention to paragraph 251. What did Philip  
27 say to you about being in the Franklin Unit?

28 A. Well, in 251, that was actually prior to being moved  
29 to the Franklin Unit. He said that if, if he was going to  
30 be moved, because Maude put it to him that that's what she  
31 wanted to do, if he was going to be moved he would not come  
32 out of his room because he didn't want to get his head  
33 punched in.

34  
35 Q. And then, after he moved, and this is at  
36 paragraph 252, you went to see him and he told you that he  
37 was staying in his room because of the fear that he had  
38 about being attacked?

39 A. Yeah, as he had said the day before, he began  
40 self-isolating, he was unwilling to leave his room due to  
41 fear of being attacked by other residents. He was tasked  
42 with keeping himself safe from further head injuries, he  
43 wasn't attending school, he wasn't eating, he was not  
44 leaving his room.

45  
46 Q. And there was a quite precise thing that he said to  
47 you that he feared from another young person, Frank?

1 A. Yes.

2

3 Q. Just for context, Frank is someone who you were aware  
4 had been implicated in potential harm to Henry and Jonathan  
5 earlier on?

6 A. Absolutely.

7

8 Q. What was it that Philip was worried about from Frank  
9 and other Franklin residents?

10 A. He said two specific things: one was that he was going  
11 to kill him and one was that he was going to make him a  
12 wife.

13

14 Q. And, as I understand it, there was subsequently an  
15 interim Centre Support Team meeting in which you tried to  
16 get Philip moved?

17 A. Yes.

18

19 Q. That's at paragraph 255 of your statement. What was  
20 the response from the Operational staff to your proposal  
21 that he should be removed?

22 A. That was quite a horrific conversation. He was  
23 ultimately moved. It was - I don't think there was any  
24 sort of understanding or consideration to the reasons that  
25 I was stating: it was essentially, just, like, "Okay, we'll  
26 move him", but he was moved back into the Franklin Unit  
27 within a week.

28

29 Q. And one of the things you then go on to say is that,  
30 after he was moved back into the Franklin Unit he was  
31 attacked violently by Frank on successive days?

32 A. He was violently assaulted by Frank, which had been  
33 flagged in writing by numerous staff, for five days in a  
34 row.

35

36 Q. So, he was assaulted five days in a row?

37 A. Yes.

38

39 Q. And that was documented ultimately, that Frank had  
40 been targeting Philip?

41 A. Yes, absolutely, it was documented that Frank was  
42 likely to target him before he was moved back into the  
43 Franklin Unit.

44

45 Q. Can I ask you then briefly about another young person  
46 who we're calling Margaret? Do you need to take a minute?

47 A. No.

1  
2 Q. So, I'm drawing your attention to paragraph 278 and  
3 following of your statement, and Margaret's a young person  
4 who we've heard about already through the evidence of  
5 another witness. But you were asked to speak to Margaret  
6 about a particular issue because of, and perhaps I'll do it  
7 this way: you say in your statement that Margaret was  
8 someone who during your time at the centre was blamed for a  
9 sexualised incident that had occurred to her prior to you  
10 starting your work?

11 A. Yes.

12  
13 PRESIDENT NEAVE: Q. Alysha, do you need a little break?  
14 A. I'm okay, I'm okay.

15  
16 Q. I know that this is a particularly disturbing matter.

17  
18 COMMISSIONER BROMFIELD: Q. I know that the unit  
19 placements and the preventable harm is quite distressing to  
20 recall and, if you need a break.

21 A. That's the bit that is the worst, that it all could  
22 have been prevented if we were heard, or if they were  
23 heard.

24  
25 MS ELLYARD: Q. Are you okay to keep going?

26 A. I am, I'll let you know though.

27  
28 Q. So I'm asking you about Margaret, I think you were  
29 aware of what had happened to her prior to you starting  
30 your work at the centre?

31 A. M'mm.

32  
33 Q. But I'm drawing your attention to paragraph 278. Can  
34 you tell us about the comments that were made about  
35 Margaret and what you were asked to do in relation to  
36 Margaret?

37 A. Yes. Apologies in advance for how crass this sounds.

38  
39 Q. That's fine.  
40 A. So, it was quite a big cohort of staff that felt this  
41 way, but there was a few more vocal people that referred to  
42 her as "a slut" for pulling her pants up, in their view, to  
43 show - to show a camel toe and to show her flaps.

44  
45 Q. This is what staff would say about this young person  
46 who was a detainee?

47 A. These are not my words. Yes.

1  
2 Q. So there was criticism of what she was wearing. What  
3 choice did she have about what she wore?  
4 A. Well, she's issued Ashley clothing, so she had very  
5 little input into what she could wear. She was given  
6 clothes to wear and she wore them, and at one stage I spoke  
7 to her about - because this was an ongoing situation and  
8 the boys in the unit would often call out things and say  
9 sexually inappropriate things. There's one girl in the  
10 centre, you know, and the staff would consistently blame  
11 her, and I was sort of thinking, "This is a good  
12 opportunity to teach the boys about some things". And I  
13 said to her one day, you know, "What's happening, I'm  
14 really confused here?" And she said, "Like, I have to",  
15 she had lost a lot of weight, she had to pull her pants up  
16 to keep them on essentially above her hips so that her hips  
17 would keep them up; they were too big.  
18  
19 Q. And so, you were asked to talk to her, weren't you  
20 about, her clothes?  
21 A. I was asked by one of the male Operations coordinators  
22 to go and remove some of her - the Ashley issued clothing  
23 and tell her to stop dressing provocatively.  
24  
25 Q. And what did you think about that request?  
26 A. Well, I refused to do that, that was mortifying.  
27  
28 Q. But did someone else in the end have that  
29 conversation, telling this young woman not to dress  
30 provocatively?  
31 A. Yes, they were adamant that it needed to be a female,  
32 so the cook from the kitchen went over to the unit and  
33 removed her clothing.  
34  
35 Q. And, as I understand paragraph 280, she was given  
36 different clothing that was not going to "rile up the  
37 boys"; is that what happened?  
38 A. Yes, that's right.  
39  
40 Q. You say in your statement that that shocked you; is  
41 that because, apart from that, it was not at all a  
42 misogynist place or because this was a particularly extreme  
43 example perhaps of concerning attitudes towards women?  
44 A. It was a highly misogynistic place. This was in  
45 regards to detainees though, which was a new thing, because  
46 having female residents wasn't particularly regular and it  
47 was - yeah, it was particularly bizarre and distressing to

1 me because she had no choice in what she was wearing; it  
2 was almost a self-fulfilling prophecy that was happening,  
3 you know, they were setting her up with clothing that  
4 didn't fit that she could then be shamed about or, you  
5 know, whether - I doubt that was intentional but that's  
6 what was sort of happening.

7  
8 Q. Can I move then to an incident that we've heard  
9 described in some evidence already, Alysha, which is an  
10 incident that occurred on 6 March 2020, and you deal with  
11 this at paragraph 281 and following in your statement and I  
12 want to ask you some questions about a particular aspect of  
13 what happened, but just to set the scene. This was a very  
14 significant incident that occurred at the centre over a  
15 period of hours where, first, four boys got access to the  
16 roof and then they broke in through the ceiling and pulled  
17 up two further children to be on the roof with them.

18 A. Yes.

19  
20 Q. Potentially one of them willingly, although query how  
21 willingly; the other one definitely not willingly, but then  
22 ultimately there was six of them on the roof for a period  
23 of time.

24 A. In the roof.

25  
26 Q. In the roof, and one of them was a child who we're  
27 calling Chris?

28 A. Yep.

29  
30 Q. And Chris, perhaps consistently with the other  
31 children we've been discussing, was a vulnerable young  
32 person.

33 A. Yes.

34  
35 Q. You came to understand, as I understand it after the  
36 incident was over, that he had had some particularly  
37 concerning experiences at the hands of the other boys while  
38 he was in the roof?

39 A. Yeah, that's correct.

40  
41 Q. Can you tell us about that?

42 A. Absolutely. It was noted on a sort of log that I read  
43 when I came into work that, when they did come down from  
44 the roof, that this one child had a [REDACTED] of some  
45 kind; there was no notes about looking into that or what  
46 that was.

47

1 I was tasked with doing what we'd call a reflection  
2 with some of the kids, which is just to go and talk to them  
3 after any particular incident and have a chat and see what  
4 was happening for them, and I went and spoke to this young  
5 person and it was - I was sort of prompted to speak to him  
6 first because I had had a conversation with the then - I  
7 don't know if it was acting or manager - who had said,  
8 because this is the one riot where the police did come in,  
9 and it was apparently said to the manager by the police  
10 that, "There was mention of a hostage situation and that  
11 there was also mention of a possible sexual assault".  
12

13 So, I talked to a few of the boys who were involved  
14 just to see what had happened and Chris disclosed to me  
15 that he had been sexually assaulted by one of the older  
16 boys who had [REDACTED]  
17 [REDACTED]  
18 [REDACTED].  
19

20 Q. And as I understand it you did pass on some of what  
21 Chris had disclosed to you but not everything?

22 A. So, what Chris said to me was that he didn't want to  
23 talk to anyone except for his particular caseworker, who we  
24 had very loose contact with but we had the ability to  
25 contact, or myself. He didn't want to talk to the police.  
26 And I said, "I'd need to talk to the manager at least", and  
27 he was okay with that, so I went and had a verbal  
28 conversation with the manager and disclosed what he had  
29 told me.  
30

31 Q. Ultimately, were any of the other young boys who had  
32 been in the roof and who were the potential assailants  
33 questioned about it as far as you're aware?

34 A. As far as I'm aware, no.  
35

36 Q. And, was there any therapy or support offered to Chris  
37 as far as you're aware in view of the fact that he'd  
38 effectively been sexually assaulted and [REDACTED]  
39 [REDACTED] up into the roof?

40 A. No, there was nothing.  
41

42 Q. The last example of the behaviour and treatment of  
43 detainees that I want to ask you about, Alysha, is about  
44 two young people who we're calling Harvey and Ben. You  
45 deal with their particular experiences at paragraphs 320  
46 onwards.  
47



1 Now, Harvey and Ben were both in Ashley in relation to  
2 very serious offending, but the particular issue I want to  
3 ask you about relates to - pardon me while I find it - Ben  
4 and Christmas. I'm drawing your attention to paragraph 308  
5 in your statement. Can you tell us in particular about  
6 arrangements that were made for Christmas and why they were  
7 special for Ben?

8 A. Yes, I can. So, it was Christmas of 2019. I opted to  
9 work Christmas Eve because I thought it would be nice, and  
10 part of that Christmas at Ashley was that little Christmas  
11 trees and decorations were provided to each of the units,  
12 which I thought was really lovely. And, it was  
13 particularly - I didn't discover this until basically, I  
14 went into one unit and said, you know, the boys were  
15 playing Nintendo or whatever and I was sort of like, "Come  
16 on, let's do our Christmas tree", and at first they were  
17 really hesitant and I thought, maybe that's because it's  
18 not very cool. But they - one of them, Ben, ultimately  
19 said to me, "I've never had a Christmas tree, I don't know  
20 what to do. Like, where do we start?" And this young  
21 person had been in care since essentially birth, and I  
22 went, "Okay, well, you know, it's going to be really  
23 awesome then, let's do this right", so we started building  
24 a Christmas tree, and he got so excited. And, you know, we  
25 had more baubles and tinsel than the tree could  
26 accommodate, but he made it work, they were stuffed into  
27 all of the crevices that you couldn't see. Anyway, the  
28 tree ended up looking very sparkly.

29  
30 Q. And then, when you came back after the Christmas  
31 break, what had happened to that tree?

32 A. Yeah, so, I'd always visit each unit each day. The  
33 other units had their Christmas trees up, this unit's  
34 Christmas tree wasn't up and I said to Ben, "Where's it  
35 gone, what's happened?" And he told me that one of the  
36 workers threw it across the room and broke it.

37  
38 Q. And how did he seem when he told you that?

39 A. Crushed.

40  
41 Q. Was there any reason that you understood that he'd  
42 been given for why a worker would destroy his Christmas  
43 tree like that?

44 A. His reason was, "Because the worker was a dickhead".  
45

46 Q. Another aspect of Ben and Harvey's situation relates  
47 to very last minute decisions that were made after Ben and

1 Harvey had received a sentence for certain offences, and  
2 you describe in your statement a very last minute decision  
3 being made so that, whilst Harvey was, as he understood it,  
4 coming from court back to Ashley, he was diverted away and  
5 unexpectedly sent to adult prison and didn't come back to  
6 Ashley after all?

7 A. Yes.

8  
9 Q. As I understand from your statement, it was such late  
10 notice that his parents came to visit him the next day,  
11 only to find that their son had been moved to an adult  
12 jail?

13 A. Yes.

14  
15 Q. Who was it who was left to give his parents that news?

16 A. It was a very distressed administration girl.

17  
18 Q. And, as part of that, as I understand it, and because  
19 of concerns about planning for Ben who might ultimately  
20 have to go to Risdon as well, you made contact with the  
21 Commissioner for Children and Young People?

22 A. I did.

23  
24 Q. What was the reason for you making contact with her  
25 office?

26 A. Because of the - I might just add that there had been  
27 a lot of thought and consideration given to Harvey and  
28 whether or not he be transferred to an adult facility, and  
29 it had been decided by a group of people who had spent a  
30 lot of time on that, that that wouldn't occur for  
31 significant reasons, so he was expecting to come back, we  
32 were all expecting him to come back and we could have done  
33 significant work to make that transition less traumatic had  
34 it been planned for: it obviously wasn't.

35  
36 I was very concerned that, because they were - they  
37 had been convicted of similar offences, that the other  
38 child, pseudonym being?

39  
40 Q. Ben.

41 A. -- Ben might, you know, we might face a really  
42 haphazard sort of last minute decision to transfer him  
43 without any planning or appropriate, you know, safety work  
44 being done, so I felt quite helpless and concerned about  
45 that and I thought that speaking to the Children's  
46 Commissioner, she could help advocate for him to stay at  
47 the centre till at least he was 18 years old.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. And, as I understand it, in making contact with the Children's Commissioner, you requested that your involvement be kept confidential from centre management?

A. Yes.

Q. And, why did you feel that you needed to make that request?

A. I was being significantly bullied by this stage and I did express to her that that would - that I didn't want to be put at further risk.

Q. And, did she keep your identity confidential?

A. No.

Q. How do you know that?

A. Because the manager, Stuart Watson, told me and essentially reprimanded me for calling her.

Q. Turning to a different topic. You describe in your statement at paragraphs 383 onwards a number of conversations that you had with a member of the Professional Services staff who we're calling "Stan" in which he told you, as you recall it, about records that he was keeping for his own purposes about behaviours that had occurred in the past at the centre?

A. Yes, I'm sorry, I'm lost, what paragraph did you --

Q. Paragraph 363 and following.

A. Yes.

Q. In particular, he gave you some information about Lester, but he also gave you a number of other names of then current staff who he said he was aware were offenders from the past?

A. Yes. The context behind that, I guess, is that I had gone to this person having learnt things that were absolutely mind bending for me, and sort of said, "What is going on here, I feel like I'm in an alternate universe, you know, things are wrong", and he explained that, yeah, things were very broken and very wrong and went into talk about, you know, he was a long-standing employee and he talked about Lester particularly, and he went on to talk about other long-standing members of staff who had, in his words, you know, "Been sex offenders and were still on site, were still sex offenders against the children in the centre", and I said, "How do you - how are you okay?" You

1 know, I'm here reporting left right and centre, you know,  
2 "How are you coping with this?" And he just said that all  
3 that he could do essentially was keep these files that he  
4 showed me on his book shelf which were, you know, various  
5 emails or complaints or reports that he'd printed off over  
6 - I'm not sure how many years, and just filed; he said  
7 that's what he felt was all he could do.  
8

9 Q. Stan's given a statement in response to a request from  
10 the Commission and he was asked about this question, and  
11 his evidence was that he has never kept records of that  
12 kind. So, is it possible that you misunderstood what he  
13 told you or the records that he gave you access to?

14 A. No, it's not possible. I sat in his office and he  
15 talked me through context behind some of the documents in  
16 the file. He said/invited me to flick through them, and I  
17 did, and I read the content of this file; so no, there is  
18 no chance.  
19

20 Q. Just going back to the question of the incident that  
21 occurred on 6 March and Chris and the suggestion that he'd  
22 been sexually assaulted. As I understand in your statement  
23 in your evidence there was some degree of communication  
24 between you and Mr Watson who was the assistant manager I  
25 think at that time?

26 A. Yes.  
27

28 Q. About whether or not there had been a disclosure by  
29 Chris of any sexual assault or anything of that kind.  
30 What's your best recollection of whether Mr Watson knew  
31 that there had been an allegation of Chris being assaulted  
32 or of what the police knew about it?

33 A. Oh, he absolutely knew that there had been an  
34 allegation. He brought it to my attention that the police  
35 mentioned a possibility of that occurring in the roof  
36 space, but then when I confirmed with him that I had spoken  
37 to the child and this is what was shared, he obviously  
38 definitely knew that that was what we were dealing with  
39 then; however, his stance about it was that it - that we  
40 could not report it to the police unless Chris wanted that.  
41

42 Q. Mr Watson, as I understand it, will say that the first  
43 he heard of the possibility of Chris being sexually  
44 assaulted was from you. Could that be right?

45 A. That's just not what happened.  
46

47 Q. And I gather he will also say that he understood from

1 what you had said that, if the police already knew about  
2 it, they would already be investigating it?

3 A. I wasn't present for the conversation that he had with  
4 the police, but I would have - yeah, I don't know what was  
5 said other than what he told me, which was that the police  
6 flagged that something might have - of that nature might  
7 have happened.

8

9 Q. Turning then to the question of an allegation which  
10 came to your notice which you then sought to report to  
11 Ms Honan about Lester. At paragraph 323 of your statement  
12 you describe being told by another long-term worker, Ira as  
13 we're calling him, of an occasion that he had witnessed  
14 some years previously in which he had seen a child, "A  
15 crying naked child on all fours in an isolation room with  
16 Lester standing behind him in the room".

17 A. That's correct.

18

19 Q. And that, as I understand it, was a disclosure that  
20 very much concerned you?

21 A. Yes.

22

23 Q. And it was a disclosure that Ira made to you in the  
24 context where he suggested that it was common knowledge  
25 that this had occurred?

26 A. I don't know if it was common knowledge that that  
27 specific incident had occurred, but certainly that these  
28 behaviours had occurred, yes.

29

30 Q. You describe in your statement making a report, I  
31 think initially via email to Ms Honan, who was the  
32 Director, of this allegation that you had heard about  
33 Lester from Ira?

34 A. Yes, so I emailed, I sent the one report to the head  
35 of HR, Ms Honan, and my two direct line managers.

36

37 Q. What was your expectation about what would happen in  
38 response to you bringing that allegation to their  
39 attention?

40 A. Well, I expected that obviously some conversations  
41 would be held rapidly, which - and, typically with a  
42 disclosure of that nature when it's regarding a staff  
43 member who was a senior staff member and currently on site,  
44 I would expect that, whilst - well, obviously, first, it  
45 would be reported to the police as an allegation by an  
46 eyewitness, and also, that the department would investigate  
47 it and that, whilst those investigations took place, that

1 person would be stood down, you know, paid or whatever is  
2 appropriate, but not able to be working with children.

3  
4 Q. After you had made your managers and HR and the  
5 Director aware of the allegation of Lester he remained on  
6 site; is that right?

7 A. Yes.

8  
9 Q. And, as I understand it, there was at least one  
10 occasion when you saw him having very direct contact with a  
11 child?

12 A. Yes.

13  
14 Q. What was that?

15 A. He was strip-searching a child.

16  
17 Q. And, did you bring that specifically to the attention  
18 of anybody given the notification that you'd already made  
19 about the allegation against him?

20 A. Yes.

21  
22 Q. And, perhaps it's obvious, but what was the concern  
23 that you had about him strip-search - again, assuming that  
24 strip-searches are occasionally appropriate, what was the  
25 particular concern that you had about him conducting the  
26 strip-search or the way in which it was being conducted?

27 A. It was my view that he ought not be on site at all  
28 while investigations were underway, but also, anyone who  
29 has serious allegations of child abuse against them - I  
30 mean, it sounds silly to say, but shouldn't be touching a  
31 child.

32  
33 Q. Can I turn then, and I'm conscious of the time,  
34 Commissioners, to some questions about your observations of  
35 staff and the experiences of staff. This is paragraph 384  
36 and following, Alysha, in your statement?

37  
38 COMMISSIONER BROMFIELD: Sorry, Ms Ellyard, do you mind  
39 just before you do?

40  
41 MS ELLYARD: Not at all.

42  
43 COMMISSIONER BROMFIELD: Q. When you became aware of  
44 this, when Ira made this disclosure or statement to you,  
45 you reported on the same day to your Director; that was my  
46 understanding?

47 A. Immediately.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. And I believe that you were then working at the centre for a further, was it about 11 months?

A. He was or I was?

Q. Both?

A. So, that happened in January. I left the site in April and he was still on site in November.

Q. I just wanted to ask what it was like for you as an employee, having made that allegation, to see that person still on site every day?

A. Thank you for asking that. I actually shared an office wall with that person. So, every morning I would - I wanted to remain professional, but I was also feeling very unheard and very helpless because, no matter how much I followed up, he was there, nothing was happening, and I knew nothing was happening because he would not be there if the appropriate measures were in place. So, it was quite torturous having to see him and try and be professional and say, "Good morning" and work alongside someone with allegations of that nature, knowing that, you know, he's working amongst the most vulnerable children in the state. I found it - I've never felt so helpless in my life, there was nothing I could do to reduce the risk.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Q. Alysha, you describe in your statement at paragraph 385 your observation that the staff in the centre fell into two groups: one group was traumatised and bullied, and the other group was doing the bullying?

A. Yes.

Q. One of the things that the Commission has heard about from a number of witnesses is the extent to which there was a mismatch between the very difficult work that people were being called upon to perform and the skills and attitudes of the people who were on site doing the job. From your observation, what was the willingness of staff on the site to change and improve their practices?

A. Are you referring to it, like, the youth workers sort of group or?

Q. If there's a distinction between the youth worker level and the operational management level, please do make that distinction.

1 A. There was probably less than a handful of staff at a  
2 youth worker level who were open and even enthusiastic  
3 about supervision and more support and changing practices,  
4 and I tried to support them quite intensively. The  
5 majority of staff on the ground were of the opinion that  
6 someone such as myself or a professional staff team member  
7 had no clue and didn't know how Ashley would work, and  
8 "What do they know, you know, we've been doing this for  
9 however many years": complete unwillingness to hear - even  
10 hear, you know, the reasoning or - and I'm not a - and I  
11 say I'm not a walk in and say, "This is how we're gonna do  
12 things now", you know, I work really hard to try and bring  
13 people on board and work with them to help them feel a  
14 really big part of a change process, and I wanted their  
15 thoughts and there was just no willingness to entertain the  
16 idea of working in a different way because they had a  
17 fundamentally - a fundamental belief that these kids didn't  
18 deserve that way of working.

19  
20 Q. At paragraph 392 and following of your statement you  
21 describe a particular incident involving a youth worker,  
22 Rupert, who you had tried to give advice and support to but  
23 who kept insisting that he wanted to act punitively towards  
24 someone, and you wrote an email, I think, to management  
25 drawing their attention to concerns you had about Rupert's  
26 practice and his need for support. What happened?

27 A. Can I, I'm so sorry, can I just go back one second,  
28 because I only half answered you.

29  
30 Q. Sure.

31 A. I talked about youth workers. There was an even  
32 greater level of resistance from management that was - I  
33 was completely obstructed with; anyone who tried to  
34 implement change was entirely obstructed. There was zero.

35  
36 Q. And so then, to go to the question of Rupert, you  
37 wrote a confidential memo to management, as I understand  
38 it --

39 A. I did, yeah.

40  
41 Q. -- raising concerns about Rupert and his practice and  
42 his need for support, and what was your expectation about  
43 what managers would do with that communication?

44 A. In that particular case, that person was in his  
45 probation period, so I saw it as a really good opportunity  
46 to work quite intensively with him to either, you know,  
47 develop his skills and help him change his practices and,



1 you know, I was prepared to offer a lot of help in that  
2 space and I outlined my concerns in detail and what I was  
3 hoping we could put in place for him; or, you know, failing  
4 that, obviously going through that process and trying very  
5 much to support him to reach a level of practice that was  
6 acceptable, then it would be an opportunity to, you know,  
7 have those discussions around whether he was a suitable  
8 long-term staff member with the practices that he was  
9 currently displaying if he was unwilling or unable to  
10 address them.

11

12 Q. And so, clearly that wasn't an email intended for his  
13 eyes?

14 A. No, no.

15

16 Q. But you came to understand that he had found out about  
17 the email?

18 A. Yes, his line leader gave it to him.

19

20 Q. And what was the outcome of that?

21 A. I sent a follow-up email to the same people saying  
22 that I had become aware that this email had been shared  
23 with the staff member and that that was extremely  
24 disappointing and risky, because that would have been  
25 distressing for him without it being delivered in a  
26 supportive way, you know, of course. He did actually take  
27 a week's leave, so he was affected by it. I would have  
28 handled that very differently if we decided to move forward  
29 with what I was suggesting, and nothing came of any of  
30 that. I never even heard back.

31

32 Q. You also describe at paragraph 396 and following that  
33 you did have some staff who did want your support and who  
34 confided in you about their own experiences.

35 A. Sorry, what paragraph?

36

37 Q. 396?

38 A. Thank you.

39

40 Q. You describe being confided in by some staff members  
41 about their own very difficult experiences?

42 A. Yep.

43

44 Q. Can you tell us a little bit about that?

45 A. Yes. There were a few, maybe a handful, again, less  
46 than 10 probably, staff; some quite unexpected staff as  
47 well, some of the sort of tougher male variety that maybe I

1 wouldn't have expected to do that, but yeah, there was a  
2 number of staff that reached out. They were very worried  
3 about raising concerns with me and quite concerned that  
4 they would get in trouble or face difficulties because of  
5 it, but they did, and certainly it appeared to me that  
6 there was - you know, that the entrenched sort of  
7 misogynistic bullying behaviours that I was seeing and  
8 experiencing were not new and that certainly other staff  
9 had been treated similarly over the years and had faced a  
10 lot of issues regarding the culture in the centre, and  
11 there was - you know, it was evidenced by very high levels  
12 of workers' compensation claims, stress claims, et cetera.  
13

14 Q. The Commission's got access to emails, including  
15 emails sent by you towards the end of your time on site at  
16 the centre which, I think from a time after Patrick Ryan  
17 had left, in which you seem to have been feeling more  
18 positive about the management at Ashley and to have felt  
19 that there was the opportunity for some improvement and  
20 that some changes had been made. Did you recall having  
21 that observation, that in the final weeks of you being on  
22 site there were what seemed to you to be some changes for  
23 the better?

24 A. There was a brief window where, with the new manager  
25 taking over and what I believed to be my Director taking  
26 some positive steps that would lead to some positive  
27 change: unfortunately, that didn't unfold.  
28

29 Q. But so, for example, there are emails, I think sent by  
30 you in early April in which you express confidence in  
31 Mr Watson or express the view that it appears that there's  
32 some positive changes which you are grateful for. You  
33 recall sending some emails like that?

34 A. Yeah, there was some positive change that Mr Watson  
35 brought that were not in place when Ms Ryan was managing  
36 the centre, and that was - I recognise that for sure.  
37

38 Q. Thank you. Just the last point that I wanted to ask  
39 you. Pardon me a moment. I'm not sure if you had the  
40 opportunity to observe the evidence that Ms Honan gave last  
41 week, Alysha, but she was asked some questions about the  
42 complaints and matters you raised with her and the way in  
43 which she responded to them. Ultimately, did you feel that  
44 she had responded in an appropriate way to the concerns  
45 that you brought to her attention?

46 A. No, not at all.  
47

1 Q. As I understand it, you ultimately made a formal  
2 complaint through formal processes about the way in which  
3 Ms Honan had responded to the various matters that you  
4 raised with her?

5 A. Absolutely.

6

7 Q. And, as I understand it, you did eventually hear back  
8 about the outcome of that complaint?

9 A. So, that was a few weeks ago that I heard back about  
10 that complaint.

11

12 Q. A few weeks ago, as in, in 2022?

13 A. Yes.

14

15 Q. And that was in relation to a complaint, I think, that  
16 you raised late last year, in about September 2021?

17 A. September, yeah.

18

19 PRESIDENT NEAVE: Q. Can I just ask: had you been spoken  
20 to by anyone else about the handling of that complaint?

21 A. No, I wasn't spoken to by even the investigator. I  
22 was told simply that her direct line leader had conducted a  
23 preliminary assessment and that there was no steps outlined  
24 as to whether there would be anything beyond a preliminary  
25 assessment, and that was what I received a few weeks ago.  
26 It was an odd document. It stated it was by the Deputy  
27 Secretary in my department who, I believe, left my  
28 department quite a few months ago, but I just got it  
29 recently and, to be completely honest, I didn't give it a  
30 great deal of credence.

31

32 Q. So, there was never a formal investigation initiated?

33 A. No.

34

35 Q. It was done by the Deputy Secretary who did the  
36 preliminary assessment and then --

37 A. Her direct line leader and I wasn't - I wasn't even  
38 approached once.

39

40 Q. You weren't spoken to?

41 A. No.

42

43 PRESIDENT NEAVE: Thank you.

44

45 MS ELLYARD: Conscious as I am of the time, Commissioners,  
46 those are my questions for Alysha, subject to any further  
47 questions that you have for her.

1  
2 COMMISSIONER BENJAMIN: No, but thank you for your  
3 evidence.

4  
5 COMMISSIONER BROMFIELD: I didn't have any further  
6 questions either. I did want to note that, in reading your  
7 statement and the many attachments that came with it, that  
8 I could see a number of times in your professional life  
9 where you worked hard to try and secure the safety of  
10 children and I wanted to thank you for that.

11 A. Thank you.

12  
13 PRESIDENT NEAVE: And thank you very much indeed for your  
14 evidence and for speaking to us, and for all the work that  
15 you put into that issue. So, thank you.

16 A. Thank you all very much.

17  
18 MS ELLYARD: And, can I invite you to take the afternoon  
19 break, Commissioners?

20  
21 PRESIDENT NEAVE: Yes, thank you.

22  
23 **SHORT ADJOURNMENT.**

24  
25 MS NORTON: Commissioners, our final witness this  
26 afternoon is Ms Veronica Burton, and I ask that the  
27 affirmation be administered, please.

28  
29 **<VERONICA BURTON, affirmed: [3.40pm]**

30  
31 **<EXAMINATION BY MS NORTON:**

32  
33 **Q.** Ms Burton, can I ask you to state for the  
34 transcript your name, professional address and occupation?

35 **A.** Sure. My name is Veronica Burton, I'm a registered  
36 psychologist currently working as a General Manager for  
37 Quality, Safeguarding and Risk across Tasmania, Victoria  
38 and Queensland for a not-for-profit Human Services  
39 organisation. My place of employment is Unit 2, No.3  
40 Reeves Street, Burnie.

41  
42 **Q.** Thank you. You've prepared a statement for the  
43 benefit of the Commission, it's a document dated 4 August,  
44 it has three annexures. Paragraph 2 of that statement  
45 states your wish that your statement be treated as  
46 anonymous. Am I right to understand you'd like to change  
47 that status to "public"?

1 A. Yes.

2

3 Q. Thank you. Subject to that alteration, is the  
4 contents of your statement true and correct to the best of  
5 your knowledge and belief?

6 A. Yes, it is.

7

8 Q. You have training as a psychologist and you've just  
9 mentioned that you're currently registered with AHPRA?

10 A. Yep.

11

12 Q. You're no longer employed by the Department of  
13 Communities, but as I understand it you have a long history  
14 of experience with Communities or its predecessor, DHHS,  
15 over 15 years of experience; is that right?

16 A. Yes, that is right.

17

18 Q. Your role as relevant to the evidence you're going to  
19 give today was as a SERT reviewer and you commenced in that  
20 role in January 2018; is that right?

21 A. Yes, that's correct.

22

23 Q. And, how long did you work as a SERT reviewer?

24 A. Until June 2020, so two and a half years.

25

26 Q. When you joined the SERT Team in 2018 it was quite  
27 new; I think the SERT team was established in late 2017; is  
28 that right?

29 A. That's correct, it was brand new, yep.

30

31 Q. Now, it was dissolved around the time that you left  
32 the role, for obvious reasons?

33 A. Correct.

34

35 Q. In your statement at paragraph 4 you say that the SERT  
36 was established to review child deaths and serious injuries  
37 across child and youth services. Now, I think you listened  
38 to the evidence of Ms Pam Honan on Friday afternoon, and it  
39 was her evidence that SERT was set up to investigate infant  
40 deaths, really for that limited purpose, and that it was  
41 intended to have a beginning and an end point?

42 A. Yes.

43

44 Q. Is that evidence consistent with your understanding of  
45 SERT's purpose?

46 A. No. My understanding of SERT's purpose was that it  
47 was established, as you said, to review child deaths and

1 serious injuries, children of all ages, so from zero to  
2 aged 18, across Children and Youth Services, so that  
3 included Child Safety Services, Family Violence services  
4 and Youth Justice services. And the purpose of the  
5 establishment of the SERT was, it was acknowledged and  
6 recognised that the Department Communities Tas required an  
7 independent team to review serious events and to make  
8 recommendations for improvement of service delivery. It  
9 was never intended to be a discrete period of time and it  
10 certainly wasn't established to review infant deaths,  
11 although some of the infant deaths we reviewed did become  
12 part of the coronal inquest towards the time that SERT was  
13 being dissolved. And, when SERT was dissolved, it was  
14 unexpected; nobody in the team expected it to occur. It  
15 was essentially, one day we were working in the SERT and  
16 the next day we were not, and it wasn't really explained to  
17 us in a satisfactory way why that was the case.

18  
19 PRESIDENT NEAVE: Q. Can I just follow up?

20  
21 MS NORTON: Yes.

22  
23 PRESIDENT NEAVE: Q. As I understand it, there's a body  
24 equivalent to the SERT Team?

25 A. Yes.

26  
27 Q. I'm familiar with one in at least one, possibly two  
28 states?

29 A. Yes.

30  
31 Q. And they're ongoing processes, aren't they?

32 A. Yes, they absolutely are, and I think part of the  
33 rationale for establishing SERT in Tasmania was that  
34 Tasmania was the only state and territory in Australia that  
35 didn't have a team for this function, which was why it was  
36 established by the then Deputy Secretary.

37  
38 PRESIDENT NEAVE: I'm sorry to cut you off.

39  
40 MS NORTON: Not at all, President.

41  
42 Q. I'd like to ask you some questions about the standard  
43 process for conducting a SERT Review and then I'll ask you  
44 about some SERT reviews that you conducted in relation to  
45 Ashley.

46 A. Yep.

47

1 Q. When you were briefed to conduct a review and given  
2 terms of reference, what was your standard process for  
3 conducting investigations in order to form findings and  
4 recommendations?

5 A. So, the standard process would be, we would look at  
6 the terms of reference and establish what we thought needed  
7 to happen; that would most often include a review of all  
8 the relevant files related to that child or young person;  
9 if possible, conversations with that child or young person;  
10 obviously sometimes that wasn't possible. Interviews of  
11 all staff that were involved in the serious event, and  
12 often staff that had been involved with that child or young  
13 person over a period of time, because often they were  
14 children that had been under the attention of Children and  
15 Youth Services for some time, so it was often looking  
16 at years' worth of history and considering how everything  
17 that had gone before led to that serious event and  
18 analysing that and understanding why that might have  
19 occurred and making recommendations and findings as to why  
20 the event may have occurred, could it have been prevented,  
21 if so how could it have been prevented, what do we need to  
22 do moving forward to, you know, put in place different ways  
23 of working, different practice, better policies, better  
24 training, better supervision, whatever we thought it might  
25 need to try to prevent something similar from happening  
26 from the future. We would also consult experts if needed  
27 and also research and evidence as required depending on,  
28 you know, what the specific issue was that we were looking  
29 at.

30  
31 And then we would prepare a report and that would be  
32 presented to the Serious Event Review Committee which was  
33 comprised of heads of department across Tasmania, so we  
34 had - it was comprised of the Police Commissioner, the Head  
35 of Education, the Head of Mental Health Services, the Head  
36 of - I think I said Education, but department heads, and we  
37 would present our reviews to them; they would endorse the  
38 recommendations usually, and the responsibility for  
39 progressing those would sit with the Deputy Secretary of  
40 Communities Tasmania who would be required to report back  
41 to the committee on progress towards those recommendations.

42  
43 Q. And in that ordinary course that you've just  
44 explained, would you as the reviewer or the SERT Team more  
45 generally receive updates over time about the progress of  
46 recommendations? Would you receive those updates or do you  
47 provide your recommendations and that's the end of it and

1 you move on to the next thing?

2 A. Usually our involvement would stop at the point of the  
3 recommendations being endorsed by the committee and  
4 returned back to the Deputy Secretary for action; our  
5 involvement would cease at that point usually.

6

7 Q. So you wouldn't necessarily have insight into what  
8 work was being done at the agency level to implement the  
9 recommendations?

10 A. Not formally, but we were usually aware of what was  
11 happening, but we wouldn't have a formal feedback process  
12 for that.

13

14 PRESIDENT NEAVE: Q. Can I just have follow-up on that?  
15 Let's assume that there was a SERT report to the committee,  
16 the review committee; you then review another event.

17 A. Yes.

18

19 Q. And it becomes clear from that event that things  
20 haven't changed; that the factors that led to the first  
21 serious event are still in existence. I mean, what was  
22 your approach in that situation, how did you deal with  
23 that, if it occurred?

24 A. Well, it actually occurred at Ashley Youth Detention  
25 Centre with some of - so, we were making - I was making the  
26 same recommendations all the time, and the same things kept  
27 happening. So, it did actually occur in that situation,  
28 and perhaps in others we would identify areas of practice  
29 that still haven't been addressed.

30

31 Q. How many times? Do you have off the top of your head  
32 the number of times that you --

33 A. At Ashley or in general?

34

35 Q. Ashley - both really. I'd be interested to know about  
36 Ashley?

37 A. I did four reviews at Ashley over a period of a year  
38 and all of them had the same recommendations around  
39 different things. So, we would identify those themes and  
40 trends and we would raise them back through to our Director  
41 and Deputy Secretary via an internal consultation process  
42 and look at, you know, make suggestions on how that might  
43 be remediated.

44

45 Q. And, do you care to make any comments about the extent  
46 to which there was a change over that period of time?

47 A. I'm happy to make a comment.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. Thank you.

A. In my opinion there was very minimal change over that period of time.

PRESIDENT NEAVE: Thank you.

MS NORTON: Q. I'd just like to put to you something that Ms Honan said in her evidence that goes to this point about the recommendations. She was talking in particular about the recommendations you made in relation to an incident involving a child we're referring to as Henry, we'll come to that in greater detail in a minute. She said of the 17 recommendations that you made in that report, that they were interdependent, large in scale, not able to be finalised quickly, and that the work had been steadily progressing over the 16-month period.

Do you have any reflection you'd like to offer on that characterisation, particularly in light of the evidence you've just given that you kept making the same recommendations over and over again?

A. I think the comments, they are big recommendations because a big overhaul is required, so there's absolutely nothing to be gained in making small changes here and there in a situation like there is or has been at Ashley Youth Detention Centre. So, yes, they are big recommendations, and some of them are linked also, however, that was not the first time that the Director or indeed the Deputy Secretary had been aware of those issues.

Like I said, I had been flagging them for some time, so there was plenty of time to start to think about a strategy and a way forward. Having said that, there were small things that could have been done to change things quite quickly in small ways that would have made a significant difference along the way while working towards those bigger goals.

Q. And in the four SERT reviews that you conducted successively in relation to Ashley, did you see any evidence that those small but meaningful changes were being made?

A. Not really, no. I mean, there was the engagement of the Australian Childhood Foundation, but again, that was towards the end of the time, that was in relation to the last - I think the last review that I did. No, I didn't

1 see anything.

2

3 COMMISSIONER BROMFIELD: Ms Norton, I just had a question.

4

5 MS NORTON: Yes.

6

7 COMMISSIONER BROMFIELD: Q. I understand that  
8 implementation of big recommendations can take time. My  
9 understanding for the SERT process, though, is that there's  
10 normally a two-step process, in that, there is the  
11 endorsement of the recommendations by the committee, and  
12 then it transitions into an implementation phase. On my  
13 reading of the information it doesn't look like there was  
14 an endorsement or acceptance of the recommendations  
15 formally. Are you aware or have I got that wrong?

16 A. No, you're correct. To the best of my knowledge the  
17 reviews that I did at Ashley Youth Detention Centre were  
18 never presented to the committee.

19

20 COMMISSIONER BROMFIELD: Thank you.

21

22 MS NORTON: Q. Do you have any understanding of why that  
23 usual process that you've been speaking of and that  
24 Commissioner Bromfield's just referred to, do you have any  
25 understanding of why that might have been subverted with  
26 the Ashley reviews?

27 A. I can hypothesise why. I think possibly it was  
28 related to the incidents themselves in terms of what they  
29 were. So, there was some incidents with young people  
30 getting onto roofs and being in a standoff and damaging  
31 property, those sorts of incidents where nobody was injured  
32 that we were aware of, so they weren't seen as a serious  
33 incident from that point of view, perhaps that was why they  
34 weren't presented to the committee because they didn't fit  
35 within the, I guess, brief of SERT, because they weren't -  
36 there was no injuries. Doesn't make all that much sense to  
37 me, but maybe that was why.

38

39 There was also concerns around maintaining  
40 confidentiality of the SERT reports. There had been some  
41 leaks to Parliament around the time that we were preparing  
42 reports for Child Safety Services, and we wondered if that  
43 was maybe why the Ashley reports didn't get presented,  
44 because they were worried about --

45

46 PRESIDENT NEAVE: Q. They were worried about  
47 embarrassment?

1 A. Exactly, yes.

2

3 PRESIDENT NEAVE: Thank you.

4

5 MS NORTON: Q. You said before - and I think you  
6 characterised in the statement, in your efforts to try and  
7 understand why these reports weren't provided to the  
8 committee, you say they might have been regarded as  
9 near-misses.

10 A. Yes.

11

12 Q. Again, we'll come in greater detail to this incident  
13 involving Henry, but your finding was that there was a  
14 sexual assault?

15 A. Yes.

16

17 Q. That the core event was a sexual assault; that's not  
18 something which anybody could mistake as a near-miss, is  
19 it?

20 A. No.

21

22 Q. Could I just clarify: of the four SERT reports you did  
23 in relation to Ashley, did any of them to your knowledge go  
24 to the committee?

25 A. Not to my knowledge, no.

26

27 Q. Are you aware of any reports you've prepared for SERT  
28 in relation to other agencies, not Ashley, that didn't go  
29 to the committee?

30 A. No, I'm not aware of any.

31

32 COMMISSIONER BENJAMIN: Q. If I may interrupt. There  
33 was a coronal report which was delivered in 2021, wasn't  
34 there?

35 A. Yes.

36

37 Q. Was that by Coroner Taggart?

38 A. Taggart, yes, it was.

39

40 Q. She made some positive comments about the SERT  
41 process, didn't she?

42 A. Yes.

43

44 COMMISSIONER BENJAMIN: Thank you.

45

46 MS NORTON: Q. I just want to go back to what you said  
47 earlier about your usual process when you were briefed to

1 conduct a review, and you talked amongst other things about  
2 needing access to records, access to young people and staff  
3 who might be involved with the young person.  
4

5 When you're dealing with a review in the context of a  
6 particular agency how important is the cooperation of the  
7 agency to the thoroughness of your review?

8 A. It's vital, particularly at Ashley Youth Detention  
9 Centre because, with Child Safety Services, for example, as  
10 an employee of Communities Tasmania I did have access to  
11 the electronic files of Child Safety Services, so it wasn't  
12 so dependent on staff providing those records.  
13

14 With the centre it was different. There was an  
15 electronic system but it wasn't utilised, pretty much  
16 everything was paper file, so we depended upon the  
17 management at the centre to provide us with those when we  
18 attended the centre, and we - also, it was difficult to  
19 engage with workers to arrange times to interview as well,  
20 that I needed cooperation of management at the centre to do  
21 that as well.  
22

23 Q. You say in your statement, at paragraph 9, that the  
24 main liaisons you had at the centre were Patrick Ryan?

25 A. Yes.  
26

27 Q. And another employee who we're referring to as Lester.  
28 In paragraphs 10 and following you make some observations  
29 about Mr Ryan and your interactions with him. Would you  
30 like to summarise for the Commissioners what those  
31 impressions were?

32 A. Sure. Mr Ryan always made sure to be there when I  
33 arrived. I would be taken to his office where he would  
34 brief me on the incident that I was reviewing and would  
35 give me his opinion on what he thought had happened, what  
36 he thought were the issues. He controlled who I spoke to  
37 at the centre and where I went. I couldn't go anywhere in  
38 the centre unless somebody took me because every door is  
39 locked and I needed somebody to escort me wherever I needed  
40 to go, so I was completely at, you know, the mercy of  
41 Mr Ryan in that regard.  
42

43 Q. Can I ask you: you said he would direct who you would  
44 speak to. Was it the case that you would go in and say, "I  
45 need to speak to these four people" or?

46 A. Sometimes, if we had that information, because the  
47 file-keeping was so poor, we often didn't know which staff

1 were involved and who we needed to speak to; we just  
2 couldn't get that information, so often it would be, he  
3 would check the rosters and tell us which staff had been on  
4 shift at that time and then arrange for them to come into  
5 the centre to talk to us.

6  
7 Q. And so, in what sounds like a situation where you had  
8 a bit of an information vacuum, at least at the beginning  
9 of an investigation, would you agree that you were highly  
10 dependent on Mr Ryan, or his delegate, identifying the  
11 right people for you to speak to?

12 A. Yes, for the most part, yes.

13  
14 COMMISSIONER BROMFIELD: Q. I assume that during your  
15 time at SERT you do enquiries into areas such as  
16 residential care units?

17 A. Yes.

18  
19 Q. Was the process similar there? Did you have someone  
20 meet you, give you a précis, their opinion? What was  
21 different?

22 A. The provision of information was - information was  
23 provided more freely, I guess. There was collaboration,  
24 there was a willingness to engage and discuss and to  
25 welcome the process, for want of a better term in terms of,  
26 from the point of view of, what can we learn from this,  
27 rather than a defensiveness, which is often what I  
28 experienced at the centre.

29  
30 COMMISSIONER BROMFIELD: Thank you.

31  
32 MS NORTON: Q. You make reference in your statement, and  
33 it's at paragraph 13, to a comment that Mr Ryan made to you  
34 about "clean slate" and "everyone who comes into the  
35 centre, every young person starts with a clean slate".  
36 Now, to the person on the street that might sound like a  
37 good thing, but it seems from your statement you were  
38 concerned by that attitude. Can you explain to the  
39 Commissioners why that mentality concerned you?

40 A. Well, if I'm doing a review of young people and an  
41 incident that occurred that involved them, I want to know  
42 who they are, where they've come from, what brought them to  
43 the centre, what history of trauma they might have that  
44 might explain, you know, what happened in the incident;  
45 provide a context for their behaviour, provide a context  
46 for how we might better support them. It's just, in my  
47 opinion, impossible to do a thorough review without that

1 information and Mr Ryan just didn't agree with me. So, if  
2 I was to ask, "Who is this person, what's he here for,  
3 what's their history?" He would, you know, just say, "No,  
4 they're on a clean slate, I don't like to talk about what  
5 they've done or why they're here; as far as I'm concerned,  
6 when they're here, they're here and it's a clean slate", so  
7 it was hard to get the information.  
8

9 Q. And, in your professional opinion, is it possible with  
10 that type of an attitude to run a centre that's therapeutic  
11 in anything other than name?

12 A. I don't see how you can, because you can't provide  
13 therapy if you don't know what you're providing therapy  
14 for.  
15

16 Q. You make some observations about Lester in your  
17 statement and I just want to invite you to comment on a  
18 particular comment that Lester made to you in relation to  
19 boys' genitals. You refer to it at paragraph 14. What was  
20 that comment and why was it so concerning to you, or what  
21 did it suggest to you about Lester's attitude to the young  
22 people at the centre?

23 A. We were - I was leaving the centre and he was seeing  
24 me out, and the boy, some of the boys were swimming in the  
25 pool and it was a cold day and I made a comment, it was an  
26 outdoor pool and I made a comment, "I can't believe they're  
27 in the pool swimming on a day like this", and he laughed  
28 and said, "Yeah, I told them that when they get out they're  
29 not gonna have penises anymore, they'll only have vaginas",  
30 and at the time I guess I was taken aback, it's not a  
31 professional comment to make, it's not a way that you would  
32 talk to another professional from an external service  
33 reviewing, you know, the centre; it just seemed at the very  
34 least inappropriate and uncomfortable. And at the worst, I  
35 guess, it felt uncomfortable that he would be talking about  
36 the boys' genitals and joking about that. I mean, yeah, it  
37 felt uncomfortable and inappropriate to me.  
38

39 Q. In paragraph 23 of your statement you make some  
40 observations about the culture at Ashley that you observed  
41 having regard to your interactions over the four SERT  
42 reviews. Would you just like to summarise for the  
43 Commissioners what your observations were about the  
44 culture?

45 A. So, it was things that staff that I spoke to as part  
46 of my reviews would tell me, things that they were  
47 concerned about. So, feeling - so, being bullied when they

1 expressed opinions different to the core group of managers  
2 and staff that seemed to have more, I guess, sway or power  
3 at the centre than they did. So, if they --  
4  
5 Q. I'm sorry.  
6 A. No, that's all right.  
7  
8 Q. I just wanted to ask you who you regarded - you made  
9 reference there to the core members of management?  
10 A. Sure. So, Patrick Ryan --  
11  
12 Q. Lester?  
13 A. Lester, Maude, and some youth workers, I can't recall  
14 their names, but the three management positions. So,  
15 people felt very intimidated to raise issues with them.  
16 They described incidences of verbal abuse, being yelled at,  
17 being physically assaulted on a couple of occasions by  
18 being pushed, and prevented from leaving a room, and being  
19 spoken over the top of in meetings when they tried to  
20 express concerns about decisions that were being made in  
21 meetings.  
22  
23 Q. Can I ask - I don't want to cut you off, please.  
24 A. That's all right, I was going to say having their  
25 reports that they were writing changed or being told to  
26 change their reports, and shred the originals.  
27  
28 Q. These are incident reports, as I understand it?  
29 A. Yes.  
30  
31 Q. Did you learn anything from your discussions with  
32 staff about minute keeping practices in relation to  
33 meetings; who was responsible for minute taking?  
34 A. Minutes, I can't recall who was responsible, but staff  
35 did disclose to me that they were instructed to  
36 change minutes.  
37  
38 Q. Instructed by whom?  
39 A. From memory, Patrick Ryan and Maude.  
40  
41 Q. I think you referred to that on pages 21 and 22 of  
42 your report.  
43 A. Thank you. The review report?  
44  
45 Q. Of the review report, yes.  
46 A. Yes.  
47

1 Q. What you've just described sounds like a culture in  
2 which staff might be quite reticent to raise concerns with  
3 management. How was it that people in that environment  
4 came to speak to you as part of your report? How was it  
5 that they were comfortable speaking to you?

6 A. They said to me that they - because I wasn't working  
7 at the centre, I wasn't employed by the centre, that they  
8 felt that maybe the issues that would be communicated  
9 outside of the centre to people that needed to know that  
10 might be able to do something about it. They felt, as I  
11 said, uncomfortable raising them with staff within the  
12 centre. They liked the fact that the SERT was independent  
13 in their view and, which it was, and that they felt safer  
14 to raise issues. And what tended to happen was, once we  
15 were at the centre doing a review and talking to staff,  
16 other staff that weren't involved in that review, would  
17 make contact with us because their colleagues had told them  
18 that we were there and we were happy to talk to people if  
19 they wanted to, so we would have people independently  
20 contacting us to talk to us.

21

22 Q. And so, was that one way that you managed to gain  
23 access to people in addition to those who Mr Ryan, for  
24 example, told you were the relevant people?

25 A. Absolutely, because once they knew who we were, they  
26 were able to contact us, yes.

27

28 Q. I'd like to ask you some questions about, you  
29 explained at the beginning of your evidence your usual  
30 practice for conducting a review, and I'd like to ask but  
31 how that usual practice - the extent to which you were able  
32 to follow that usual practice when you conducted reviews at  
33 Ashley.

34

35 You've already mentioned that access to documents was  
36 difficult, that there were paper-based records, and I  
37 assume that you had some concerns about accuracy of  
38 records --

39 A. Absolutely, yeah.

40

41 Q. -- having regard to what staff had told you about  
42 practices there?

43 A. Mm-hmm. So, accuracy of the records was an issue,  
44 just whether the records were there or not; often they  
45 weren't, they were missing or they couldn't be found when I  
46 requested them. And, not just file records but minute  
47 meetings, emails that were relevant, things like that.



1 Some reviews I just had to complete without the documents  
2 because they were just not provided. Also - sorry, I've  
3 lost my train of thought.  
4

5 Q. Perhaps come back to it if you recall. Can I ask you  
6 about access to residents? You say in paragraph 10 that it  
7 was very difficult to get access to residents because they  
8 were in secure units and you couldn't talk to them easily.

9 A. Yes.

10  
11 Q. Presumably in some cases, and the incident involving  
12 Henry is one, that you couldn't speak to the victim of the  
13 incident?

14 A. Yes.

15  
16 Q. Did it also mean on occasion that you couldn't speak  
17 to other witnesses of incidents?

18 A. Yes, it was unusual that we were able to speak to the  
19 young people at Ashley. There was one review where I was  
20 able to, but for the most part - and that wasn't this  
21 review with Henry.

22  
23 Q. No.

24 A. I did request to speak to Henry, and I was informed by  
25 my manager that I wouldn't be speaking to Henry because  
26 enough people had spoken to him already and there was  
27 nothing to be gained from talking to him. That was relayed  
28 to me by my manager, but I believe it was Pam Honan that  
29 told - that made that instruction.

30  
31 Q. Yes. Now, I know you heard some of Ms Honan's  
32 evidence on Friday. Her evidence is that she doesn't  
33 recall making that direction and that she acknowledged that  
34 it would be to the detriment of an investigation to be  
35 denied access to the victim. But, whoever the direction  
36 came from, the outcome of it was that you didn't have  
37 access to Henry?

38 A. I didn't speak to Henry.

39  
40 Q. You made mention of a review that you done - where you  
41 did, it was one of those rare occasions where you did gain  
42 access to a young person, and I think that was somebody who  
43 we're referring to as Max?

44 A. Yes.

45  
46 Q. It's referred to in your statement.

47 A. Yes.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Q. You say in your statement that, although the interview you had with him was as confidential as it could be, that you had two youth workers --

A. Outside the door.

Q. -- immediately outside the door. Do you think, reflecting on that access, that you were able to speak to Max in an environment where he would have felt comfortable to speak frankly about what had happened to him?

A. No, I don't think so. He was not comfortable with us.

Q. And the allegation that had been made by Max was that he had been assaulted by youth workers in an air lock?

A. In an air lock, that's correct, and then had been placed in a timeout room unsupervised, yes, and he - he did not want to speak to us about it; in fact, he withdrew the allegation while we were talking to him.

Q. Before I come in more detail to the Henry incident, I just wanted to invite you to share your reflections on the department's response to the reviews you conducted into Ashley, and I'll just quote from paragraph 36 of your statement. You say:

*Trying to get the Department of Communities to understand the issues at AYDC was like banging my head against a brick wall. I felt like no-one wanted to hear about the issues or do anything about them.*

Was there anything you'd like to say to elaborate on that experience?

A. Other than, it was incredibly frustrating. As I said, you know, there was four reviews that I conducted, there was other reviews conducted by one of my colleagues, two or three others. The ones that I conducted, I was identifying similar or identical issues every time, making the same findings, making the same recommendations, and sending them to where they were supposed to go for action, and then nothing would change, and then I would go back and there'd be the same issues, and I really did just feel like management, my management, the executive management of Children and Youth Services were just not interested or not able - I don't know. I never got any feedback. The reports would go and I would not hear anything back about what was happening.

1  
2           When issues were raised with me as part of the reviews  
3 that weren't necessarily related to the incident, so things  
4 that people would raise with me about concerns, I would  
5 communicate those in a memo to the Director separately as  
6 would be the appropriate process: I didn't ever get much of  
7 a response from those, and I felt just so frustrated that I  
8 could see the risk and I couldn't - I couldn't do anything  
9 about it.

10  
11 Q.   Having regard to the evidence you've just given, I  
12 want to again share some evidence that was given by  
13 Ms Honan on Friday and get your reaction to it. She gave  
14 evidence that she thought SERT reviews were helpful and  
15 that Ms Clarke, the Deputy Secretary, shared that view.  
16 She said:

17  
18           *Having a level of specialisation and*  
19           *independence for a review over serious*  
20           *incidents was really useful and in fact*  
21           *critical.*

22  
23           Does that evidence accord with your experience of the  
24 support or the engagement you received from the executive?  
25 A.   Not at all, not in relation to Ashley Youth Detention  
26 Centre. Quite the opposite; it felt as if they were  
27 disregarding what we were trying to raise.

28  
29 Q.   Moving then to the report you did into the incident  
30 involving Henry. Now, this was an incident that occurred  
31 on 7 August in 2019 and it involved a sexual assault of one  
32 young person, Henry, by two other young people who we're  
33 referring to as Albert and Finn and it involved the use of  
34 a water bottle. Now, despite the fact that the incident  
35 occurred in August 2019, the referral to you and the terms  
36 of reference didn't come into effect until December of  
37 that year, some four months later. Did you have any  
38 insight or understanding into why there was a delay between  
39 the event and the referral?

40 A.   No.

41  
42 Q.   Did you have a sense that that delay impacted at all  
43 on your ability to conduct a thorough investigation?

44 A.   Well, I mean, yes: you know, memory, people's memory  
45 of events changes over time. Four months is a reasonably  
46 long time in the life of a detention centre when things are  
47 happening all the time and whether or not staff can

1 accurately recall what happened; also, there's no  
2 opportunity to review documentation and such in real-time.

3  
4 Q. The two young people who perpetrated the assault that  
5 we're considering here, Albert and Finn, I think you were  
6 here when Alysha gave evidence earlier today --

7 A. Yes.

8  
9 Q. -- that these two young people had a history of  
10 harmful sexual behaviours?

11 A. Yes.

12  
13 Q. Would you agree that detainees with those  
14 characteristics, extreme care needed to be taken in terms  
15 of who those detainees were placed in a unit with?

16 A. Yes, absolutely.

17  
18 Q. Henry was somebody who had a care plan in place, and  
19 that care plan said quite plainly that he was not to be  
20 placed in a unit with Albert and Finn?

21 A. Yes. Yes, it did.

22  
23 Q. Can you recall how it was that he came to be placed in  
24 a unit contrary to what the care plan provided?

25 A. As part of the review I did look at the  
26 decision-making process, and I don't think there was any  
27 definitive reason other than a decision was made to place -  
28 officially, a decision was made to place him there.

29  
30 I did get some unofficial reasons from staff when I  
31 interviewed them which were around that he was placed in  
32 the Franklin Unit because the other two boys would keep him  
33 in line.

34  
35 Q. Yes, and I think you said in your statement that that  
36 was something you were told by multiple staff members?

37 A. On several occasions, yeah.

38  
39 Q. You also refer in your report, I think it's at about  
40 page 23, you say:

41  
42 *It was reported that many staff are*  
43 *intimidated by Finn and Albert and that*  
44 *both residents are given input into*  
45 *decision-making regarding what happens in*  
46 *their unit.*

- 1 A. Yes.  
2
- 3 Q. Were you concerned by those staff reports about the  
4 extent to which Finn and Albert were, (1) having input into  
5 allocation decisions, but (2), the extent to which  
6 Operations staff might have been relying on them to manage  
7 the behaviour of other residents?  
8 A. Yes, very much so.  
9
- 10 Q. Are those practices ever appropriate in your mind?  
11 A. Not in my opinion, no.  
12
- 13 Q. Now, you viewed the CCTV footage of the event and you  
14 describe in your report what you saw. I don't need you to  
15 do that now, but was there any doubt in your mind that what  
16 you witnessed involved a sexual assault?  
17 A. No, none whatsoever.  
18
- 19 Q. Again, you refer in your report to an internal  
20 briefing that I think Mr Ryan prepared for the benefit of  
21 the Secretary in relation to the event.  
22 A. Yes.  
23
- 24 Q. That internal briefing stated that:  
25  
26 *The incident involved an unsuccessful*  
27 *attempt to remove Henry's trackpants.*  
28  
29 That's incorrect, isn't it?  
30 A. Yes, it is.  
31
- 32 Q. It was plain on the footage that you saw that his  
33 trackpants had in fact been pulled down?  
34 A. Yes, absolutely.  
35
- 36 Q. Some of the documents and emails that were sent around  
37 the time of the incident, including I think some CST  
38 minutes, refer to the incident as involving silly behaviour  
39 or, you know, young people joking around. Do you think  
40 those labels are appropriate to describe what you saw?  
41 A. No. What I saw was a sexual assault and that was the  
42 way the behaviour should have been described.  
43
- 44 Q. I think, when Ms Honan gave evidence, again on Friday,  
45 it was put to her that your conclusion was that it was a  
46 sexual assault, and she re-characterised the finding; she  
47 said that it was an attempted sexual assault. That's not

1 the case, is it? your conclusion was that it was a sexual  
2 assault?  
3 A. Yes.  
4  
5 Q. Would you agree that it also might be characterised as  
6 an attempted rape?  
7 A. Yes, from the way that the drink bottle was being  
8 used.  
9  
10 Q. Positioned?  
11 A. Positioned, used. Yes, I think so.  
12  
13 COMMISSIONER BROMFIELD: Ms Norton, can I interrupt?  
14  
15 MS NORTON: Yes.  
16  
17 COMMISSIONER BROMFIELD: Q. In terms of the young people  
18 in the unit, my understanding from the investigation was  
19 that the way this came about was that the young people in  
20 the unit had made a disclosure about it.  
21 A. That's right.  
22  
23 Q. Do you recall the way that they characterised it?  
24 A. Yes, I think the young people's - if I may, said that  
25 they had "tried to fuck him with a Coke bottle", was the  
26 words, the quote that was in the incident report.  
27  
28 MS NORTON: Q. Can I just ask a question by way of  
29 clarification. When you spoke earlier about the  
30 conversations that you had with staff members who felt  
31 reluctant to speak up against management, can you clarify  
32 whether those comments were made by members of the  
33 Operations Team or Professional Services or both?  
34 A. Both.  
35  
36 Q. Both, thank you.  
37  
38 PRESIDENT NEAVE: Q. Can I just ask a question; this  
39 might now be the appropriate moment to ask it. You would  
40 have heard Alysha's evidence before?  
41 A. Yes.  
42  
43 Q. And she described a situation in which she escorted, I  
44 think, you and maybe other members of the SERT Team, to an  
45 office where there was a filing cabinet.  
46 A. Yes.  
47

1 Q. And I think it was Lester --  
2 A. Yes.  
3  
4 Q. -- who didn't permit you to take the files away?  
5 A. Yes.  
6  
7 Q. Or to open them, I think?  
8 A. Yes. Yes, we didn't look at them on that occasion.  
9  
10 Q. You didn't look at them, and you were not able to look  
11 at them because of the control that was being exercised by  
12 Lester?  
13 A. Yes. And also, he said that he didn't know where they  
14 were; he couldn't find them.  
15  
16 Q. And I think she referred to seeing a file with  
17 somebody's name on it?  
18 A. She found one, yes. And then we couldn't look at that  
19 one.  
20  
21 Q. And you couldn't look at that one?  
22 A. Yes.  
23  
24 Q. So, you agree with her account of what occurred on  
25 that particular occasion?  
26 A. Yes.  
27  
28 Q. Where was that? And that was in relation to the Henry  
29 SERT Review?  
30 A. Yeah, from memory it was.  
31  
32 Q. Was that at the beginning of the process?  
33 A. Yes, it was, because we did come back and we did get  
34 access to some files at that point. I believe the  
35 management had changed at that time.  
36  
37 Q. Was that much later? How much later was that,  
38 roughly?  
39 A. Maybe a month or so, yeah.  
40  
41 PRESIDENT NEAVE: I see, thank you.  
42  
43 MS NORTON: Q. Can you recall who the new manager was at  
44 that time?  
45 A. He's not got a pseudonym? The --  
46  
47 Q. You can just say it. I think it'll --

1 A. Stuart. So, Stuart Watson.

2

3 Q. Stuart Watson, that's fine. He doesn't have a  
4 pseudonym; that's fine. In your statement you  
5 characterise, I think - sorry it's in your report - the  
6 approach of management as being deliberately obstructive.  
7 In labelling management's approach in that way, are there  
8 any other incidents that you would or features of the  
9 management response that you would point to for the  
10 Commissioners in addition to those that you have just  
11 outlined?

12 A. So I guess the failure to provide me with the files,  
13 obviously, but then there was also other information that I  
14 requested from Mr Ryan, which was his weekly reports that  
15 he sends to his director, some of the CST minutes. There  
16 were some other - one other thing that we requested and  
17 requested and requested, because - it was quite relevant,  
18 because the information was different; there was so many  
19 inconsistencies with minutes and files and briefings that  
20 we wanted to see them, and in the end after making many  
21 requests, we just continued and finalised the review  
22 without them, yeah.

23

24 PRESIDENT NEAVE: Q. So, just to clarify, you were  
25 trying to make a comparison between --

26 A. Exactly.

27

28 Q. -- the way in which particular events had been  
29 described?

30 A. Yes.

31

32 Q. You'd seen enough --

33 A. Exactly.

34

35 Q. -- to identify number of inconsistencies, but you  
36 wanted to do a full job on that?

37 A. Yes, exactly.

38

39 Q. And you weren't able to do so?

40 A. No.

41

42 PRESIDENT NEAVE: Thank you.

43

44 MS NORTON: Q. You also say that, in addition to the  
45 copies of the information or the incident reports that  
46 lesser provided to you, one day I think you were going back  
47 to your car and Alysha provided you with different versions



1 of the same incident reports.

2 A. (Witness nods.)

3

4 Q. I know that it's a while ago now and you no longer  
5 have the versions, the two versions you were provided with,  
6 but what's your best recollection sitting here today about  
7 the differences between those two versions of the reports?

8 A. So, the detail in terms of the incident and the  
9 severity of the incident mostly, and, from memory, the  
10 length of time that the young people were unsupervised.

11

12 Q. And, can you recall whether - was it the version that  
13 Lester provided that was, if I can use the word, in some  
14 way sanitised?

15 A. Yes.

16

17 Q. And was there more detail in the version Alysha  
18 provided?

19 A. Yes.

20

21 Q. Now, you've exhibited to your statement the versions  
22 Lester gave you but not the versions that Alysha gave you.  
23 Do you have any knowledge of where those versions might be  
24 today?

25 A. So, my usual practice with any hard copy paper files  
26 was to take them back to my office, scan them, and save  
27 them on our secure file system for SERT; also kept paper  
28 files in my office. So, I don't have a clear memory of  
29 exactly doing that with those documents, but that was the  
30 process that I followed, so I can say with, you know,  
31 almost 100 per cent confidence that that's what occurred.  
32 My files in my office went missing, so I wasn't able to  
33 check.

34

35 PRESIDENT NEAVE: Q. This is the hard copies went  
36 missing?

37 A. Yes.

38

39 Q. But what about the computer, the scanned documents?

40 A. Well, I would have saved them on the SERT files, but I  
41 left the department and I wasn't able to access them  
42 anymore, so I don't know; they should be there still.

43

44 Q. Was this the only time that paper copies went missing?

45 A. All of my files went - all of my files and reports in  
46 relation to Ashley Youth Detention Centre went missing; all  
47 of my hard copies that I was filing in my office.

1  
2 MS NORTON: Q. And I think that you provided some  
3 further detail about that in paragraph 26 of your  
4 statement. I think after you finished up in the SERT role,  
5 you asked a colleague to get your reports from your office,  
6 but they were gone?  
7 A. Yes.  
8  
9 Q. You'd left them in the office thinking --  
10 A. I would be back.  
11  
12 Q. -- that you would go back?  
13 A. Well, I'd originally been on leave without pay. So I  
14 thought I'd be going back when I made my decision to resign  
15 my position permanently, and became aware that there was,  
16 you know, some enquiries and interest in what was happening  
17 at the centre. I asked my colleague to get them so I would  
18 have them, and they were gone.  
19  
20 COMMISSIONER BROMFIELD: Q. Sorry, it just wasn't clear  
21 from the statement. Was it only the Ashley files that were  
22 gone?  
23 A. Well, those are the ones I asked - no, it was all of  
24 them, yeah. Sorry, yeah, it would have been everything,  
25 yeah.  
26  
27 MS NORTON: Q. I'd like to turn to the findings and some  
28 of the key findings in your report in relation to Henry.  
29 You found that the transfer to the Franklin Unit was  
30 contrary to his care plan, which we've already spoken  
31 about, which was quite plain that he shouldn't reside with  
32 Albert and Finn, and you go so far as to say that, had the  
33 care plan been followed, then the incident may well not  
34 have occurred?  
35 A. Yeah.  
36  
37 Q. You also talk about, it's not just that he was moved  
38 to the Franklin Unit but, once he was there, there was  
39 insufficient observation or supervision of him. Would you  
40 agree that very close supervision, if you like, was very  
41 important where he was residing in a unit with Albert and  
42 Finn, having regard to their history of harmful sexual  
43 behaviours?  
44 A. Yes. Actually, I believe Albert and Finn were  
45 supposed to have very close supervision orders as well, but  
46 that wasn't occurring for them either.  
47

1 Q. Yes. We've already spoken about your characterisation  
2 of the incident as a sexual assault. You also found that  
3 it should have been reported to Tasmania Police and also  
4 Child Safety Services as a matter of urgency. Now, it was  
5 reported, I think on 23 August, by Ms Gardiner who gave  
6 evidence earlier this morning, and that was following  
7 communications between her and Mr Ryan where Mr Ryan had  
8 formed the view that it was not necessary to report to  
9 Child Safety Services, and you disagreed with that?

10 A. Yes.

11

12 Q. It might be said that the communications between  
13 Mr Ryan and Ms Gardiner contained a suggestion on Mr Ryan's  
14 part that reasonable minds may differ about whether or not  
15 this ought to have been reported to Child Safety Services,  
16 and he refers to varying degrees of seriousness. In your  
17 view was this, was the question about whether a referral to  
18 CSS was necessary something about which reasonable minds  
19 could differ?

20 A. No.

21

22 Q. You say in the report that you are unable to make a  
23 finding about whether the three young people involved were  
24 offered an opportunity for debriefing. Were you able to  
25 determine whether or not appropriate support was offered to  
26 Henry following the incident?

27 A. I don't recall. I don't recall 100 per cent. From  
28 memory, I believe there was no support offered. I was told  
29 by Mr Ryan that conferencing process had occurred, but when  
30 I requested the records of those conferencing meetings,  
31 they weren't provided, so I was unable to - I didn't know  
32 if they had or not.

33

34 Q. I think the documents show that the conferencing  
35 didn't ultimately take place. Putting that to one side,  
36 having regard to the fact that this incident involved a  
37 sexual assault, was conferencing an appropriate response?

38 A. No. No.

39

40 Q. And I think you explain in your statement why that's  
41 not the case. You also say that Albert and Finn shouldn't  
42 have been moved to the orange colour, but rather to the red  
43 colour?

44 A. Red, yeah.

45

46 Q. And you refer also on page 22 of your report to the  
47 fact that the intention was, or you were told by staff that

1 the intention was that they wouldn't be moved off orange  
2 until conferencing had occurred?

3 A. Yes, that's correct.

4  
5 Q. If we assume that no conferencing occurred, were you  
6 surprised to then find that - and you refer again to this  
7 in your report - that Albert and Finn were moved to green  
8 very quickly?

9 A. Green, yes, absolutely. They were returned to green  
10 really quickly, and, in my view, that was completely  
11 inappropriate and risky.

12  
13 Q. Did you find any evidence in your investigations of  
14 Albert and Finn being given appropriate interventions to  
15 recognise and seek to provide them with support in relation  
16 to their harmful sexual behaviours?

17 A. I didn't find any evidence to suggest. There was one  
18 comment written by one of the young people, I can't  
19 remember which - I think it might have been Finn. He wrote  
20 on the incident report, "We were only joking around". As  
21 far as I know that was the only engagement that was had  
22 with them around that incident.

23  
24 Q. The Commission's heard evidence, including from  
25 Ms Gardiner this morning, I think, about the fact that  
26 often harmful sexual behaviours are indicative of trauma in  
27 the lives of the people who perpetrate those behaviours.  
28 When you have regard to the fact that one of the objectives  
29 of Ashley Youth Detention Centre is to provide young people  
30 with opportunities for rehabilitation, do you see the  
31 failure to engage in appropriate therapeutic interventions  
32 for Finn and Albert as being a failure in terms of  
33 providing appropriate opportunities for rehabilitation?

34 A. Yes, absolutely. I think it's negligent that, with  
35 the knowledge that we had, or that Ashley had, about these  
36 young people - and it was very clear from the centre  
37 records that they had a history of assaultive behaviour,  
38 physical and sexual assaultive behaviour, but as far as I  
39 could see, there was nothing being put in place or provided  
40 to them to address those behaviours, give them the  
41 opportunity, you know, to change their behaviour or to  
42 support them in any way. And indeed, putting young people  
43 into their unit that they are going to be able to assault  
44 is almost as harmful to them as it is to the young people  
45 they're assaulting. And so, it's negligent in terms of all  
46 of those young people and it's a complete failure on behalf  
47 of what is supposed to be a therapeutic and safe service.

1  
2 Q. And so, to summarise that, it seems to be your view  
3 that the centre failed Albert, Henry and Finn in its  
4 response to this incident?  
5 A. Yes, absolutely, yeah.  
6  
7 Q. One of the explanations --  
8  
9 COMMISSIONER BROMFIELD: Sorry.  
10  
11 MS NORTON: Yes?  
12  
13 COMMISSIONER BROMFIELD: Q. I believe from the file  
14 there was another young person who was present?  
15 A. Yes, there was.  
16  
17 Q. From the CCTV footage after the event, both the person  
18 who was assaulted and them were seen re-tying the  
19 drawstrings of their tracksuit pants?  
20 A. Yes.  
21  
22 Q. It indicates that, I guess, there was another victim  
23 in the room in terms of fear.  
24 A. Absolutely. Fear, yeah. Absolutely. And not just  
25 the tying of the pants, but throughout the incident it was  
26 obvious that he was frightened by his body language, and he  
27 tried to make himself really invisible while that assault  
28 was occurring, and he was obviously uncomfortable and  
29 frightened and, yeah, absolutely he was a victim as well.  
30  
31 COMMISSIONER BROMFIELD: Thank you.  
32  
33 MS NORTON: Q. One of the explanations that was offered,  
34 I believe, at the CST meeting, in relation to Albert and  
35 Finn's behaviour, was that they'd been long-term residents  
36 at the centre and that a degree of sexual frustration was  
37 to be expected. What's your reflection on what that  
38 indicated about the understanding of harmful sexual  
39 behaviours at the centre?  
40 A. Well, I think it demonstrated that there was no  
41 understanding or very limited understanding of harmful  
42 sexual behaviours at the centre. Also that the fact that  
43 that sort of behaviour could be justified or explained,  
44 almost excused, because they would be sexually frustrated  
45 is just entirely inappropriate and just creates a setting  
46 of so much risk for them and the other kids.  
47

1 Q. Because it suggests, doesn't it, that the sexual  
2 assault of Henry could be explained by a reference to a  
3 normal expression of sexual behaviour?

4 A. Yes.

5

6 Q. And in this case the incident was anything but a  
7 normal expression of sexual behaviour; it was a harmful  
8 sexual behaviour?

9 A. Absolutely, yes.

10

11 PRESIDENT NEAVE: Q. Isn't it like the rationalisations  
12 that people used to give of rape?

13 A. Yes, exactly.

14

15 Q. Constantly, you know, that rape was justified because  
16 this poor chap was frustrated: I mean, it's an  
17 extraordinary proposition to be making, isn't it?

18 A. Yes, absolutely, yeah.

19

20 MS NORTON: Q. And, not only is it extraordinary for the  
21 reasons that the President has just explained, but it also  
22 portrays that the centre was ill-equipped --

23 A. Absolutely.

24

25 Q. -- not only to recognise the true nature of the  
26 behaviours --

27 A. Yes.

28

29 Q. -- but, by extension, to assist them and provide  
30 opportunities for rehabilitation?

31 A. Yes, because you're also sending a message to the  
32 older boys that that behaviour is okay and that's an  
33 acceptable way to express frustration.

34

35 PRESIDENT NEAVE: Q. And when you leave it's an  
36 acceptable behaviour, too, presumably?

37 A. Yes.

38

39 Q. It's the message that, if you're sexually  
40 frustrated --

41 A. That they can, yep.

42

43 Q. -- you can attempt to rape anyone?

44 A. So, that opportunity for social learning and behaviour  
45 change is gone. Yeah - well, they've learned something,  
46 but not what you want them to learn.

47

1 MS NORTON: Q. I think that covers - I know there are a  
2 range of other recommendations, and we have the benefit of  
3 your report. I just wanted to ask a few questions. You  
4 refer in your statement that in addition to the 17  
5 recommendations that you made here, that there were also  
6 recommendations in addition to other SERT reviews you  
7 completed, but some other memos, I think, that you sent to  
8 Ms Honan raising broader concerns about the centre that  
9 didn't follow within the strict terms of reference that  
10 you'd been provided with?

11 A. Yeah.

12  
13 Q. And I think it's your evidence, but I want to confirm  
14 it, that you didn't receive responses from Ms Honan to  
15 those memoranda?

16 A. The only response I recall receiving was through my  
17 manager, verbal response through my manager, and it was in  
18 response to raising some concerns around Lester and the  
19 historical and more recent allegations of sexual abuse that  
20 had also been raised by Alysha. So, the response that I  
21 got back through my manager from Ms Honan was that Alysha  
22 tended to be hysterical and I should take what she said  
23 with a grain of salt.

24  
25 Q. Yes, and I think that, in fairness to Ms Honan, she  
26 gave evidence on Friday that she couldn't recall making  
27 those statements and you won't be able to --

28 A. I don't know if she did, that was what was relayed to  
29 me.

30  
31 Q. What was reported to you, yes. You referred earlier  
32 to big recommendations being contained in this particular  
33 report but it not being the first time that the Director  
34 and the Deputy Secretary would have been aware of them.  
35 Are you able to clarify, when you say Director and Deputy  
36 Secretary, who you're speaking about there?

37 A. So, currently? At the time?

38  
39 Q. No, at the time that you provided your four SERT  
40 reviews?

41 A. So, the Director was Pam Honan, the Director of Youth  
42 Justice Services, and the Deputy Secretary was Mandy  
43 Clarke.

44  
45 Q. And so, is it your concern that those two members of  
46 the executive, Ms Honan and Ms Clarke, were disregarding or  
47 at least not acting on, to your knowledge, the concerns

1 that you were raising consistently?

2 A. Yes. If they were, I didn't know about it, but yeah.

3

4 Q. Yes, and it's possible that they were and you didn't  
5 know, but it didn't come to your attention?

6 A. No.

7

8 Q. You mentioned at the beginning - and I'm conscious of  
9 the time, we won't be very much longer - but you mentioned  
10 that the SERT was dissolved in May or June of 2020 without  
11 any warning and you really had no explanation for why that  
12 was the case. Is there anything you'd like to add in  
13 relation to the circumstances in which SERT was dissolved?

14 A. Sure. It's my opinion that the decision to dissolve  
15 SERT was made because of the issues that we were raising;  
16 because we were, I guess, causing trouble and trying to  
17 raise - draw attention to issues. There was a comment made  
18 by one of the other Directors, not Ms Honan, but one of the  
19 other directors that, "We shouldn't be airing our dirty  
20 laundry in public", in relation to the SERT reviews, so  
21 it's my opinion that the dissolution of SERT was related to  
22 that.

23

24 Q. My last question concerns reforms, and in your  
25 statement you talk about ways in which the situation at  
26 Ashley could be improved or indeed at the replacement  
27 centres could be improved. I'd be interested to hear what  
28 you see as being the main barriers to reform within the  
29 centre and at the executive, and in particular at the  
30 executive level whether the barriers are related to  
31 individual personalities, culture, or both?

32 A. I think the barriers are related to both. I think the  
33 barriers are related to the fact that we don't have a  
34 trauma-informed framework for the centre. But, in order to  
35 have a trauma-informed framework for the centre or centres  
36 as we go forward, that needs to be embraced by the  
37 executive, by management; it needs to be a top-down  
38 approach to change, otherwise the barriers will remain. If  
39 the framework, whatever it ends up being, and the  
40 therapeutic service is not embraced by executive, it won't  
41 be successful.

42

43 PRESIDENT NEAVE: Q. So, leadership is crucial; is that  
44 what you're saying?

45 A. That's what we have to have, yes, the leadership and  
46 the buy-in from that level, otherwise it's pointless.

47



1 MS NORTON: Q. I've just been asked to ask one final  
2 question.

3 A. Sure.

4

5 Q. It always says when you say "it's my last question".  
6 You mentioned before a comment being made by a member of  
7 the executive that, "We don't like to air our dirty  
8 laundry", I think you identify the executive in your  
9 statement.

10 A. I do.

11

12 Q. But, for the benefit of the transcript, do you recall  
13 who made that comment?

14 A. Yes, and I'd just add that it was, again, made to me  
15 by my manager.

16

17 Q. Yes, second-hand.

18 A. Second-hand. So, that was the Director of the Child  
19 Safety Services, Claire Lovell.

20

21 MS NORTON: Thank you. Commissioners, I have no further  
22 questions for Ms Burton.

23

24 COMMISSIONER BENJAMIN: I don't have any questions, but I  
25 want to thank you for providing and giving this evidence,  
26 in particular changing your evidence from confidential to  
27 public. That means, not only we three Commissioners know  
28 what is happening at Ashley Youth Detention Centre and the  
29 young people for whom they were responsible, but the  
30 broader community can hear and understand what it is that  
31 is going on up there at that centre. So, thank you.

32 A. You're welcome.

33

34 COMMISSIONER BROMFIELD: Q. I did have one question, but  
35 I do echo Commissioner Benjamin's sentiments.

36 A. Thank you.

37

38 Q. When you sent these reviews up about Ashley and you  
39 didn't hear anything back, I just wanted to give you the  
40 opportunity to make any personal reflection on the impact  
41 for you as a professional on raising concerns and of going  
42 into what, for you, was a vacuum?

43 A. Yeah. I mean, it has had an impact on me - nothing  
44 like what the impact has been on some of the staff that  
45 were actually at the centre all the time. But certainly,  
46 you know, I came into the job because I thought I could  
47 help to improve services, and I felt like nothing was

1 changing, nothing was happening, so the frustration; and  
2 also the worry of what actually was happening at the centre  
3 and what might be happening to the young people up there  
4 and not being able to do something about it is constant,  
5 yep, still.

6  
7 COMMISSIONER BROMFIELD: Still, m'mm.

8  
9 PRESIDENT NEAVE: Well, I'd like to endorse the comments  
10 that my fellow Commissioners have made.

11 A. Thank you.

12  
13 Q. Thank you very, very much for making your statement  
14 public, because I think it's absolutely vital if these  
15 issues are going to be addressed. We have to air dirty  
16 linen in public sometimes in order to bring about  
17 appropriate change - not that I would have used that  
18 expression, but picking up on it, in order to bring about  
19 appropriate change we have to expose these dark matters.  
20 So, thank you very much.

21 A. You're welcome. Thank you.

22  
23 MS NORTON: Commissioners, that concludes the evidence for  
24 today.

25  
26 **AT 4.46PM THE COMMISSION WAS ADJOURNED TO**  
27 **TUESDAY, 23 AUGUST 2022 AT 10.00AM**