



# REPORT OF CASE STUDY NO. 30

The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse.

ISBN: 978-1-925289-58-9

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The response of Turana, Winlaton and Baltara,  
and the Victoria Police and the Department of Health and  
Human Services Victoria to allegations of child sexual abuse.

April 2016

## COMMISSIONERS

Justice Jennifer Coate  
Mr Robert Fitzgerald AM  
Mr Andrew Murray



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# Preface

## The Royal Commission

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The Letters Patent provided to the Royal Commission require that it ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’.

In carrying out this task, we are directed to focus on systemic issues but be informed by an understanding of individual cases. The Royal Commission must make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs.

For a copy of the Letters Patent, see Appendix A.

### Public hearings

A Royal Commission commonly does its work through public hearings. A public hearing follows intensive investigation, research and preparation by Royal Commission staff and Counsel Assisting the Royal Commission. Although it may only occupy a limited number of days of hearing time, the preparatory work required by Royal Commission staff and by parties with an interest in the public hearing can be very significant.

The Royal Commission is aware that sexual abuse of children has occurred in many institutions, all of which could be investigated in a public hearing. However, if the Royal Commission were to attempt that task, a great many resources would need to be applied over an indeterminate, but lengthy, period of time. For this reason the Commissioners have accepted criteria by which Senior Counsel Assisting will identify appropriate matters for a public hearing and bring them forward as individual ‘case studies’.

The decision to conduct a case study will be informed by whether or not the hearing will advance an understanding of systemic issues and provide an opportunity to learn from previous mistakes, so that any findings and recommendations for future change which the Royal Commission makes will have a secure foundation. In some cases the relevance of the lessons to be learned will be confined to the institution the subject of the hearing. In other cases they will have relevance to many similar institutions in different parts of Australia.

Public hearings will also be held to assist in understanding the extent of abuse which may have occurred in particular institutions or types of institutions. This will enable the Royal Commission to understand the way in which various institutions were managed and how they responded to allegations of child sexual abuse. Where our investigations identify a significant concentration of abuse in one institution, it is likely that the matter will be brought forward to a public hearing.

Public hearings will also be held to tell the story of some individuals which will assist in a public understanding of the nature of sexual abuse, the circumstances in which it may occur and, most importantly, the devastating impact which it can have on some people’s lives.

A detailed explanation of the rules and conduct of public hearings is available in the Practice Notes published on the Royal Commission's website at:

[www.childabuseroyalcommission.gov.au](http://www.childabuseroyalcommission.gov.au)

Public hearings are streamed live over the internet.

In reaching findings, the Royal Commission will apply the civil standard of proof which requires its 'reasonable satisfaction' as to the particular fact in question in accordance with the principles discussed by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336:

... it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal...the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.

In other words, the more serious the allegation, the higher the degree of probability that is required before the Royal Commission can be reasonably satisfied as to the truth of that allegation.

## Private sessions

When the Royal Commission was appointed, it was apparent to the Australian Government that many people (possibly thousands) would wish to tell us about their personal history of child sexual abuse in an institutional setting. As a result, the Commonwealth Parliament amended the *Royal Commissions Act 1902* to create a process called a 'private session'.

A private session is conducted by one or two Commissioners and is an opportunity for a person to tell their story of abuse in a protected and supportive environment. As at 5 April 2016, the Royal Commission has held 4,962 private sessions and more than 1,543 people were waiting to attend one. Many accounts from these sessions will be recounted in later Royal Commission reports in a de-identified form.

## Research program

The Royal Commission also has an extensive research program. Apart from the information we gain in public hearings and private sessions, the program will draw on research by consultants and the original work of our own staff. Significant issues will be considered in issues papers and discussed at roundtables.



## This case study

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In Case Study 30, the Royal Commission into Institutional Responses to Child Sexual Abuse examined the response of Turana Youth Training Centre, Winlton Youth Training Centre, Baltara Youth Training Centre, the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors) to allegations of child sexual abuse.

The public hearing was held from 17 August 2015 to 28 August 2015 in Melbourne.

The scope and purpose of the hearing was to inquire into:

- the experiences of former child residents at Turana Youth Training Centre, Winlton Youth Training Centre and Baltara Reception Centre between the 1960s and early 1990s
- the responses of Turana, Winlton and Baltara and their staff members to child sexual abuse of former child residents of Turana, Winlton and Baltara between the 1960s and early 1990s
- the past and current policies and procedures of the:
  - Victoria Police
  - Department of Health and Human Services Victoria (and its relevant predecessors)
  - in relation to children and young people in youth training, reception and youth justice centres in the State of Victoria
- any related matters.

## Executive summary

In Case Study 30, the Royal Commission examined the responses of three state-run institutions in Victoria to allegations of child sexual abuse in the 1960s to 1990s. The responses of the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors) (the Department) were also examined. Former child residents gave evidence of their experiences of sexual abuse at the three state-run institutions in Victoria which held children removed from parental care:

- Turana Youth Training Centre (Turana)
- Winlaton Youth Training Centre (Winlaton)
- Baltara Reception Centre (Baltara).

Turana was an institution for boys and young men at Parkville in Melbourne. It operated between 1955 and early 1990s, when it was redeveloped as the Melbourne Youth Justice Centre.

Winlaton was an institution for girls and young women at Nunawading in Melbourne. It began to operate in the mid-1950s. In 1993 it was relocated and became the Parkville Youth Residential Centre.

Baltara was an institution for boys at Parkville in Melbourne. It opened in 1968 and closed in 1991.

## Child welfare in Victoria from the 1880s to the 1990s

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### Role of the Department

#### Removal from parental care

Since 1864, children in Victoria can be removed from parental care if:

- they are thought to be ‘neglected’ (later described as ‘in need of care and protection’) or
- they have been charged or convicted of a criminal offence (a ‘juvenile offender’).

The legislation in Victoria defined these children as ‘wards of the department’, but they were also known as ‘wards of the state’ or ‘state wards’.

Since 1954, a single government department has been responsible for all children removed from parental care. The department has undergone a number of name changes since 1954. Today it is known as the Department of Health and Human Services.

Between 1954 and 1970, the Director of the Department was the legal guardian of all children removed from parental care. The Director had power to place children in state-run institutions. From 1970, the Director continued to be the legal guardian of children deemed in need of care and protection but only had legal custody over juvenile offenders by way of physical control and supervision.

### Establishment of state-run institutions

Before 1954, charitable and religious organisations cared for children removed from parental care. The Department had no effective supervision of these institutions. Government funding was based on payments for the care of individual children rather than direct funding to the institutions. The only state-run institution that the Department operated before 1954 was the Royal Park Receiving Depot for Girls and Boys (later known as the Turana Youth Training Centre).

From 1954, the Department began establishing state-run institutions to accommodate children removed from parental care.

By the 1960s, the types of institutions that the Department could establish included:

- reception centres
- remand centres
- youth training centres
- children's homes.

During the 1970s and 1980s, there was a significant decline in the number of wards of the Department. By the mid-1990s, most state-run institutions were closed or redeveloped.

### Role of the Victoria Police

Historically, the Victoria Police had considerable involvement in youth justice and child welfare. The Victoria Police had powers to:

- remove children from parental care if they were suspected of being in need of care and protection
- apprehend children suspected of committing criminal offences
- apprehend residents of state-run institutions who had absconded.

The Victoria Police continues to have these powers and has considerable involvement with youth justice centres today.

## Survivors' experiences at Turana, Winlaton and Baltara

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### Sexual abuse

The Royal Commission received evidence from 13 former residents of Turana, Winlaton and Baltara, who described the sexual abuse they experienced at the hands of staff members, social workers and other residents.

One further survivor witness gave evidence of sexual abuse perpetrated by her father while she was a resident at Winlaton. Her experience and the institutional response of Winlaton and Department staff to her disclosures of sexual abuse are set out in section 5.

All of the survivor witnesses gave evidence of the devastating impact sexual abuse has had on their physical wellbeing, mental health, employment, family life and relationships. Some survivor witnesses gave evidence that the abuse they suffered ruined their lives. Many survivor witnesses suffered and continue to suffer from depression, alcohol and drug abuse, and difficulties in maintaining relationships with others.

### Other forms of abuse

Many survivor witnesses also described suffering emotional and physical abuse at the institutions. Some of the survivor witnesses described being placed in solitary confinement or being forced to do menial tasks as punishment by some staff members. The punishment administered and the methods of control that some staff members used were cruel, dehumanising and degrading.

At Turana, the punishments that some staff members inflicted, such as scrubbing brickwork with a toothbrush, were designed to keep residents occupied and compliant and were an informal means of command and control. The forms of punishment were a feature of the culture of the institution and were not mandated by formal policies or procedures.

At Winlaton, some survivor witnesses gave evidence that they were subjected to internal medical examinations and strip searches. We accept that these experiences were degrading, humiliating and invasive and that the residents viewed them as sexually abusive. Internal medical examinations were not always explained to residents and sometimes they occurred without their consent. There were no formal policies or procedures for strip searches and no oversight by senior staff members.

## Reporting of child sexual abuse at Turana, Winlaton and Baltara

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### Disclosures of abuse

The Royal Commission heard evidence that some survivor witnesses reported the sexual abuse at the time it was occurring. These survivor witnesses said that they were not believed or were punished for reporting the sexual or physical abuse. This discouraged them from disclosing further incidents of sexual abuse.

### Reasons for not disclosing abuse

Some survivor witnesses did not report sexual abuse at the time it was occurring because they were afraid that staff would punish them or there would be retribution from other residents. There was a culture at the institutions that any resident who reported on other residents was labelled a 'lagger' or a 'dobber'.

Other survivor witnesses did not report being sexually abused because they did not think they would be believed or did not know to whom they could report.

### Reporting to social workers

The Department employed social workers to visit and work with residents and their families, but some survivor witnesses gave evidence that this arrangement did not help them to report sexual abuse. We are satisfied that the Department's employment of social workers did not prevent, or facilitate the reporting of, sexual abuse because:

- some residents did not know their allocated social worker
- some residents were not visited by their allocated social worker or were visited infrequently
- some social workers did not foster a relationship or environment in which residents felt comfortable reporting the sexual abuse they experienced
- social workers were not trained to prevent, or facilitate the reporting of, sexual abuse of residents.

## Responses to complaints of child sexual abuse at Turana, Winlaton and Baltara

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The Royal Commission heard evidence that a number of factors at the institutions contributed to the response (or lack of response) of staff members to reports of sexual abuse.

### The institutional environment

Some former staff members gave evidence that the institutions fostered a culture of authority, command and control rather than focusing on the care and welfare of residents. The Royal Commission heard evidence that this 'old-school' system of brutal care often led to, and allowed, systemic abuse in the institutions.

Between the 1960s and 1970s, some staff members had limited knowledge and awareness of child sexual abuse at Turana, Winlaton and Baltara.

### Policies and procedures for responding to reports of child sexual abuse

Before the 1980s, the supervising Department did not have policies, procedures or practices for receiving and responding to reports of sexual abuse of residents.

Although some of the institutions developed their own written policies in the form of manuals of instructions, the manuals did not make any reference to risks of sexual abuse to residents in the institution or how to respond to those risks or actual reports of sexual abuse.

Dr Eileen Slack, the Superintendent of Winlaton in 1980, developed and introduced a formal procedure for dealing with grievances. This policy provided that incidents of 'sexual assault' were 'serious incidents' rather than 'major offences' and could be dealt with by Chief Youth Officers. The policy did not require that the incident be reported to more senior staff or to police. It also did not contemplate the sexual abuse of a resident perpetrated by staff members.

During the 1980s and early 1990s, the Department developed a number of policies on sexual abuse allegations. These policies were not adequate for receiving and responding to complaints of sexual abuse of residents in the institutions.

### Recruitment and training of staff to respond to reports of child sexual abuse

Former staff members told the Royal Commission that the Department recruited staff who were not equipped for the job. Some staff members who were recruited at the institutions were ex-army, ex-police officers and imposing figures. Mr Grant Holland, a former Youth and Child Care Officer, said that at Baltara the Department recruited a staff member from the United States who was later

found to have criminal convictions for sexual offences against children in the United States.

Both senior and junior staff members said that, when they started working at the institutions, they did not feel trained or equipped to care for children. The Royal Commission heard that there was limited training for staff members and that the training that was given either did not cover or did not satisfactorily cover topics such as recognising and responding to sexual abuse.

We are satisfied that there was an absence of checks to ensure that staff members were qualified, experienced and equipped to care for children. The lack of training undermined the capacity of staff to recognise the risk of sexual abuse of residents and respond effectively to their complaints.

## Placement of residents

Although the legislation made a distinction between ‘children in need of care and protection’ and ‘juvenile offenders’, the Royal Commission heard evidence from both former residents and former staff members that, in reality, both groups of children were often placed together in the same institution and sometimes in the same section. Also, younger children were sometimes placed with older children in the same section of the institution.

The Royal Commission heard evidence that, although efforts were made to separate children in need of care and protection from juvenile offenders and younger children from older children, this was not always possible. Some residents had to be held securely and some residents had to be placed in sections that they would not normally be in because there was not enough room elsewhere.

The risk of sexual abuse of children by other residents was increased by placement and interaction of children admitted as wards of the Department with children committed as juvenile offenders, and of older children with younger children.

## Supervision of residents

### Staffing levels

A number of survivor witnesses gave evidence of the supervision they received at the time they experienced sexual abuse. Some survivor witnesses were sexually abused at night in dormitories far from staff offices or in areas out of sight or not easily accessed by staff members.

At each institution, residents were locked into their rooms at night and a single night officer supervised each section. A more senior officer oversaw the entire institution at night. The Royal Commission heard that this was an insufficient number of staff, particularly for sections that accommodated approximately 15 to 30 residents. Former Superintendents of Turana and Winlaton gave evidence that this was raised as a problem with the Department, but the response of the Department was that this was a matter of ‘budget processes’.

## Physical environment

The physical environment also made it difficult to provide effective and full supervision. Some bedrooms could only be observed through a small observation slit and some rooms and passages were obscured from the view of staff.

## Overcrowding

Overcrowding also hindered the provision of adequate supervision. When the institutions were overcrowded, residents were placed in sections based on the availability of beds as opposed to compatibility, suitability and safety.

The Royal Commission heard evidence that the Department was aware that overcrowding was a problem, but it favoured other alternatives rather than extending the facilities at Turana.

We are satisfied that the supervision of residents was inadequate to keep them safe from sexual abuse, particularly at night.

## Communication of reports of child sexual abuse within the institutions

Mid-level staff members such as Senior Youth Officers and Chief Youth Officers were responsible for reporting incidents (including sexual abuse) to the Superintendent and executive staff.

The Royal Commission heard evidence that it was not uncommon for incidents to get 'lost in the bureaucracy' or for senior staff members to instruct Youth Officers not to submit or to 'water down' an incident report.

We are satisfied that, in practice, mid-level staff members were relied upon to respond to complaints of sexual abuse of residents. The culture among some mid-level staff prevented reports of sexual abuse of residents being passed on to senior management.

## Role of the Superintendent and Deputy Superintendent

Mr David Green, former Superintendent at Turana, said that he did not receive any reports of sexual abuse of a resident perpetrated by staff but was informed of sexual abuse between residents. He said that he relied on mid-level staff to respond to allegations of sexual abuse of residents by investigating and preparing a report.

Dr Slack, former Superintendent at Winlaton, gave evidence that, although she was aware of the possibility of sexual abuse of residents, she never received any formal reports of sexual abuse perpetrated by either a staff member or another resident and was only aware of one incident of



sexual abuse of a resident. She said that she expected her Deputy Superintendent, Ms Marilyn Minister, to draw incidents of sexual abuse to her attention. She accepted that there was no policy or procedure to ensure that she would receive this information.

Ms Minister contested this evidence. She submitted that Dr Slack's evidence was inconsistent with other evidence before the Royal Commission, including:

- the vulnerability of residents of Winlaton
- the referral of some residents to the Children's Court Clinic for psychiatric assessment
- the development of policies and procedures on sexual abuse at Winlaton
- documentary records of intra-familial sexual abuse
- Dr Slack's practice of interacting regularly with residents both socially and to provide counselling.

We accept Ms Minister's points as to the likelihood of wider knowledge of sexual abuse at Winlaton. However, there was insufficient evidence at the public hearing that Dr Slack received more than one report of sexual abuse of a resident.

We are satisfied that the internal communication, management and reporting procedures in place at Winlaton were not effective in ensuring that the Superintendent was aware of reports of sexual abuse of residents.

We are also satisfied that, during the period that Dr Slack was the Superintendent of Winlaton, she did not ensure that there was adequate supervision, management and oversight of staff to protect residents from sexual abuse.

## Communication of reports of child sexual abuse to external authorities

The Royal Commission heard that it was not general practice for incidents of sexual abuse to be reported to the Department or the Victoria Police. Before the 1980s there were no formal policies or procedures in place at Turana, Baltara or Winlaton for reporting complaints of sexual abuse to the Director of the Department or the Victoria Police.

### Communication with the Department

The Department provided little or no oversight of the institutions. The responsibility for day-to-day operations, including responding to complaints of sexual abuse of residents, was delegated to senior staff members. Mr Holland gave evidence that there was no opportunity to directly contact the Department to raise incidents of sexual abuse of residents. He said that any contact with the Department had to be channelled through senior staff members and that anyone who ignored this procedure risked losing their job.

## Communication with Victoria Police

Similarly, as a matter of both policy and practice, senior management was responsible for reporting incidents such as sexual abuse of residents to the Victoria Police.

Given that:

- mid-level staff were relied upon to respond to complaints of sexual abuse of residents
- some mid-level staff prevented reports of sexual abuse being passed on to senior management,

it was problematic that reports to the Victoria Police were left to senior management. As a result of this procedure for reporting, we consider it highly likely that incidents of sexual abuse of residents were ultimately not reported to the Victoria Police.

## 'Aversion therapy' and the response to Mr Robert Cummings' disclosures of abuse

A survivor witness, Mr Robert Cummings, gave evidence that, when he reported being sexually abused by other residents at Turana, staff concluded that he was a homosexual and referred him for treatment to 'cure' him of his homosexuality.

Mr Cummings said that he had about 12 sessions of 'aversion therapy'. During the therapy he sat on a chair with electrode wires attached to his ankle. He said he watched a slide show of images of naked men and half-naked women and received an electric shock whenever a naked man appeared on screen.

Mr Cummings said that, when other residents found out that he was receiving this treatment, they labelled him the 'bum boy' and sexually abused him. Mr Cummings said that he disclosed this further abuse, but the person administering aversion therapy responded, 'well, we will need to up your dosage of electricity'.

We accept that this discouraged Mr Cummings from making further disclosures of sexual abuse, caused him considerable trauma and facilitated further abuse.

The Royal Commission heard evidence from Mr Thomas Verberne, the psychologist who administered aversion therapy to Mr Cummings. Mr Verberne gave evidence that, in administering aversion therapy, he had assumed that appropriate legal approvals had been given. Counsel for Mr Verberne submitted that it was appropriate for him to make this assumption.

In response, counsel for Mr Cummings submitted that Mr Verberne's argument disregarded his duties and obligations as a medical practitioner administering 'therapy' to a child. Counsel for Mr Cummings submitted that, to make a proper assessment of whether the 'treatment' was appropriate, Mr Verberne should have inquired into the possibility of sexual abuse and ensured that the consent to the 'treatment' was informed and appropriate.

We are satisfied that, even putting to one side the appropriateness of ‘aversion therapy’ to ‘treat’ homosexuality, Mr Verberne did not exercise an appropriate level of professional scrutiny in administering aversion therapy to Mr Cummings. He did not:

- make any proper independent inquiry as to the appropriateness of the ‘therapy’ for Mr Cummings
- adequately consider the possibility that Mr Cummings could have been the victim of sexual abuse rather than engaging in consensual sexual behaviour
- adequately consider Mr Cummings’ vulnerability as a ward of the Department
- adequately consider how these circumstances could affect whether Mr Cummings’ submission to ‘treatment’ was truly voluntary.

### Triad therapy at Winlaton

A number of survivor witnesses gave evidence that they participated in a group program called ‘triad therapy’ while at Winlaton. Triad therapy was developed and introduced to Winlaton by Dr Slack.

The Royal Commission heard evidence that triad therapy was the primary setting for residents at Winlaton to raise any problems they had in a group setting. It was intended to be a rehabilitation program in which residents could acknowledge and accept responsibility for their problems.

Triad therapy involved a discussion within a group of between three and 15 residents that included:

- a person with a problem
- a person that used to have the problem but now does not
- a person who never had the problem.

Some survivor witnesses gave evidence that triad therapy was not an environment that made them feel comfortable raising experiences of sexual abuse.

We are satisfied that triad therapy was an inappropriate forum to receive and respond to any reports of sexual abuse of residents because it:

- was not directed to, or suitable for, discussions about sexual abuse of residents
- was conducted in a group environment by people not trained in how to respond to those issues
- required the child participant to take responsibility or accept blame for any problems they raised. This would be an entirely inappropriate response to a report of sexual abuse by a child complainant.

## Absconding

Some of the survivor witnesses gave evidence that they absconded from the institutions because they had been sexually abused and to avoid further incidents of sexual abuse.

Manuals of instruction from Turana and Winlaton included policies about absconding. Youth Officers were required to notify senior staff, and senior staff were responsible for notifying the police.

None of the policies provided to the Royal Commission refer to sexual abuse of residents as a possible reason for absconding. Staff at Turana and Winlaton did not recognise that some residents absconded because they were being sexually abused in the institution. The staff were not trained to deal with residents who had absconded because of sexual abuse.

The Victoria Police also had policies about absconding. These policies did not contemplate that residents might abscond because of sexual abuse. Members of the Victoria Police were not required to inquire into or investigate why residents had absconded. We are satisfied that the Victoria Police were not prohibited from making those types of inquiries and could have done so if they wished.

Victoria Police Assistant Commissioner Stephen Fontana told the Royal Commission that some residents would not tell the police why they had absconded. He accepted that there may have been an attitude to children of youth training and reception centres at the time which meant that police did not inquire into why residents abscond.

Assistant Commissioner Fontana gave evidence that, today, he was not sure whether the police would routinely inquire into or investigate why residents abscond. Victoria Police policies currently contain no formal requirement that members inquire into or investigate why a resident has absconded from a youth justice facility.

## Response of the Victoria Police to complaints of sexual abuse

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There were localised arrangements between police stations and institutions that fell within their areas to deal with any incidents involving the institutions, including absconding and receiving reports of sexual abuse. Documents recording these arrangements were not produced for the public hearing.

Assistant Commissioner Fontana gave evidence that some members of the Victoria Police had the view that residents were 'juvenile delinquents' or 'troublemakers' who were not credible complainants. He said that before 2004 the police response to sexual assault was 'undermined by a culture of disbelief, a deficit in the skills and knowledge of investigators and a lack of transparency in the process'.

We are satisfied that before 2004 members of the Victoria Police were not adequately trained to recognise, understand or respond to child sexual abuse. We are satisfied that many responses to reports of child sexual abuse were entirely unsatisfactory.

The Royal Commission heard that in recent years efforts have been made to create a more productive relationship between the Victoria Police and youth justice centres and to improve the police response to, and investigation of, sexual offences more generally.

## The experience of Katherine X

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### Katherine X's disclosures of abuse in 1979

The Royal Commission heard evidence of the experience of Katherine X, who was at Winlaton in 1979, when she was 14. Katherine X was repeatedly raped by her father and disclosed this to:

- social workers of the Department before she was removed from parental care
- a Victoria Police officer who picked her up when she absconded from an institution in early 1979
- youth workers and other Department staff at Winlaton, including Mr Brian Fitzgerald, Ms Jennifer Mitchell (nee Lines), Dr Michael Groome and Ms Minister.

The Victoria Police did not comply with the applicable procedures in 1979 and failed to properly investigate the allegations that Katherine X made at that time.

### No report from Winlaton or Department to police

Winlaton and Department staff who were aware of the disclosures that Katherine X made did not report them to the Victoria Police because of their approach to incest and confusion about the decision-making process.

We are satisfied that some staff members at Winlaton viewed incest as a symptom of family dysfunction rather than a criminal offence in which the child was a victim. This resulted in some staff not recognising the seriousness of the crime of incest and its impact on the victim. The view that staff had and the approach they took failed to protect Katherine X from her father's ongoing crimes against her.

We are also satisfied that there was a lack of training to help staff to understand the dynamics of incest and the impact on the child.

### Contact between Katherine X and her father

While Katherine X was at Winlaton, her father was permitted to visit her twice. Ms Minister permitted Katherine X's father to visit Katherine X at Winlaton even though she was aware that Katherine X had been sexually abused by her father. Dr Groome was also aware that Katherine X had been sexually abused by her father.

We are satisfied that Dr Groome was in a position to give his advice and opinion as to whether to allow Katherine X's father to visit her at Winlaton. Dr Groome failed to help protect Katherine X from further harm.

Katherine X was also allowed to visit her mother on day and weekend leave. During these visits her father had access to her.

Based on the evidence before the Royal Commission, we are satisfied that staff of Winlaton and the Department released Katherine X on leave without taking any action to minimise the risk that her father would continue to sexually abuse her. This, and the visits by Katherine X's father to Winlaton, exposed her to a serious risk of further harm.

## Policies and procedures

The lack of policies and procedures for dealing with reports of sexual abuse at Winlaton in 1979 meant that:

- staff did not take clear and decisive action for the care and protection of Katherine X, which made her feel confused and helpless
- there was a lack of clarity as to who was ultimately responsible for making key decisions
- responding to reports of child sexual abuse fell to inexperienced, junior staff members.

This did not excuse or prohibit Mr Fitzgerald, Ms Lines, Dr Groome and Ms Minister from reporting the sexual abuse.

The lack of policies, procedures, training and supervision led to a failure to protect Katherine X from ongoing crimes perpetrated by her father and a failure to provide Katherine X with the psychological support she required at the time she was in the care of the Department.

## Administration of Depo Provera

While Katherine X was at Winlaton (and while still a child), she received regular injections of Depo Provera as a form of contraceptive. Depo Provera was not approved for general use in Victoria until 1991. Before that time, Depo Provera was regarded as experimental. However, it was administered to residents of Winlaton before 1991. It was used even though Dr Slack had protested against its use on many occasions.

The Royal Commission heard evidence that medical staff at Winlaton administered Depo Provera to residents even though it was unclear whether consent had been properly obtained. In Katherine X's case, the only evidence of consent was an undated consent form signed by her mother. Administration of Depo Provera to Katherine X was a wholly inadequate response to the disclosures of sexual abuse that she made, as it did not protect her from her father's ongoing crimes.

## Transfer to Hillview Hostel

In August 1979, Katherine X was transferred from Winlaton to Hillview Hostel – a non-government residential institution. During this time, Katherine X was still a ward of the Department. Winlaton and departmental staff who had been responsible for Katherine X's care at Winlaton had no further involvement in her care.

The Department did not ensure that Katherine X received continuity of service from social and welfare workers of the Department. We consider that this impeded an effective response to the disclosures of sexual abuse that Katherine X made.

## Letter to Katherine X's father

After Katherine X was transferred, staff at Winlaton sent a letter to Katherine X's father informing him of their knowledge of the 'sexual relationship' between Katherine X and her father.

We are satisfied that this letter was an inappropriate response to the disclosures of child sexual abuse because:

- it alerted Katherine X's father to the fact that Katherine X had disclosed the abuse and thereby increased the risk of further harm to her
- it was sent just after Katherine X was transferred to a less secure institution and no safeguards had been put in place to prevent her father from accessing her
- it indicated a tolerant attitude and completely downplayed to Katherine X's father the seriousness of his criminal conduct.

## Report to police in 2002

In late 1980, Katherine X moved back into her parents' house. The sexual abuse perpetrated by her father continued for 24 years, until 2005.

In 2002, Katherine X disclosed the sexual abuse to a counsellor, who reported the matter to the police. Katherine X gave evidence that she found the police judgmental and untrustworthy. She said that she felt like she was going to be charged for being a victim and ultimately denied the abuse.

Assistant Commissioner Fontana said that around that time some members of the Victoria Police did not believe reports of sexual abuse and would 'grill' victims. We are satisfied that in 2002 the Victoria Police did not properly investigate the allegations of child sexual abuse that Katherine X made.

## Report to police in 2008

In 2008, Katherine X reported the sexual abuse by her father to the police for a full investigation. She gave evidence that her father denied the allegations of sexual abuse. Katherine X said that police took a DNA sample that proved that he was the father of her sons.

In 2009, Katherine X's father was charged with sexual offences against Katherine X. He pleaded guilty to the charges in December 2009.

In 2010, Katherine X's father was sentenced to a term of imprisonment of 22 years and five months, with a non-parole period of 18 years.

## The Department

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### Acknowledgment and apology

At the public hearing, the Secretary of the Department made an apology on behalf of the State of Victoria to former residents who experienced abuse at institutions operated by the State of Victoria. The State of Victoria acknowledged that the failure of its institutions and policies led to or compounded the sexual abuse that children suffered in its care.

The Department had a duty to care for the vulnerable children who were placed in its institutions and a duty to protect them from sexual abuse. We are satisfied that, during the 1960s to early 1990s, the Department failed to protect a number of residents from sexual abuse.

### Current operation of youth justice in Victoria

Today, youth justice services for children who have committed criminal acts are totally separate from out-of-home care services for children in need of care and protection.

The Royal Commission heard evidence that there is specialised training for staff at youth justice centres to deal with and recognise children who may have been the victims of sexual abuse. There are also written policies and manuals to assist staff to respond appropriately to sexualised behaviour.

There are a number of child protection policies in place at youth justice centres, including recruitment checks, increased supervision, formal and systematic risk assessment for leave and visits, and policies requiring senior staff members to meet with any child who has absconded to discuss the reason for absconding and offer support.



There are also various forums for current residents of youth justice centres that allow them to raise concerns or disclose sexual abuse. There is also a dedicated, unrecorded telephone line to the Ombudsman and access to professional health workers, community workers and child protection workers.

If there is an allegation of sexual abuse of a resident at a youth justice centre, staff must prepare an incident report, which must be sent to the Department as soon as possible. The most senior staff member present at the time the allegation is made must also notify the police within 24 hours. Counselling, support and other specialised programs are provided to any resident who experiences sexual abuse.

## Records

The Royal Commission heard evidence from a number of survivor witnesses that it is extremely important for them to be able to access records of their time in the care of the Department as residents of state-run youth training and reception centres.

The Royal Commission heard that survivor witnesses have experienced a number of issues in accessing their records, including:

- delays in receiving files after making a request
- receiving heavily redacted documents
- receiving incomplete files
- files being destroyed
- receiving little or no support when files are received.

The Chief Information Officer of the Department gave evidence explaining why some of these issues arose and what the Department is doing to address them.

# 1 Child welfare in Victoria from the 1880s to the 1990s

In Case Study 30, the Royal Commission examined the responses of three state-run institutions in Victoria to allegations of child sexual abuse in the 1960s to 1990s. The responses of the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors) (the Department) were also examined. Former child residents gave evidence of their experiences of sexual abuse at the three state-run institutions in Victoria which held children removed from parental care:

- Turana Youth Training Centre (Turana)
- Winlaton Youth Training Centre (Winlaton)
- Baltara Reception Centre (Baltara).

Turana was an institution for boys and young men at Parkville in Melbourne. It operated between 1955 and early 1990s, when it was redeveloped as the Melbourne Youth Justice Centre.

Winlaton was an institution for girls and young women at Nunawading in Melbourne. It began to operate in the mid-1950s. In 1993 it was relocated and became the Parkville Youth Residential Centre.

Baltara was an institution for boys at Parkville in Melbourne. It opened in 1968 and closed in 1991.

This section of the report examines the history of child welfare in Victoria from the 1880s to the 1990s (including the role of the Victorian Government and the Victoria Police) and the governance structures of the three state-run institutions.

## 1.1 Role of the Department

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### Removal from parental care

In 1864, legislation in Victoria allowed for children to be removed from parental care if they were thought to be neglected ('neglected children') or if they had been charged or convicted of a criminal offence ('juvenile offenders'). These children were known as 'wards of the Department' – a term introduced in 1887.<sup>1</sup> They were also known as 'wards of the state' or 'state wards'.<sup>2</sup>

Initially, a single government department was responsible for both neglected children and juvenile offenders. This changed in 1887, when separate departments were established.

In 1954, responsibility for these children was again placed with a single government department, which was then known as the Children's Welfare Department.<sup>3</sup>

The Children's Welfare Department has undergone a number of name changes. During the period examined in this case study, it was known as the Social Welfare Branch,<sup>4</sup> the Social Welfare Department,<sup>5</sup> the Department of Community Welfare Services<sup>6</sup> and the Department of Community Services.<sup>7</sup>

Today, the Department of Health and Human Services Victoria is the department responsible for children removed from parental care. Throughout this report, this government body in all its previous and current forms is referred to as ‘the Department’.

## Guardianship of children and young people

Between 1954 and 1970, the Director of the Department was the legal guardian of children who were deemed to be in need of care and protection and juvenile offenders.<sup>8</sup> Legal guardianship was removed from the child’s parent(s) or any other guardian. Once a child was admitted or committed to the care of the Department, the Director of the Department could deal with the child in a number of different ways, including placing the child in a youth training or reception centre or another state-run institution.<sup>9</sup>

From 1970, the Director of the Department continued to be the legal guardian of children who were deemed in need of care and protection and admitted to the care of the Department.<sup>10</sup>

The Department only had legal custody or care over juvenile offenders. This meant that the Department had physical control and supervision of juvenile offenders, but the legal guardianship remained with the child’s parent(s) or guardian.<sup>11</sup>

By the 1960s, the Department had begun to employ social workers to work with children in care and their families. This was because of a growing knowledge about child development and a growing understanding of the benefits to children in retaining contact with their families.<sup>12</sup>

The role that social workers played for some residents of youth training and reception centres is set out in section 3 of this report.

## Establishment of state-run institutions

Before 1954, all institutions that cared for children removed from parental care were run by charitable and religious organisations, with the exception of the Royal Park Receiving Depot for Girls and Boys – a state-run institution that was later renamed the Turana Youth Training Centre.<sup>13</sup> There was no effective departmental supervision of these institutions and funding from the State of Victoria was based on payments for the care of individual children rather than payments to the institutions.<sup>14</sup>

From 1954, the State of Victoria began to take responsibility for providing services for the welfare of children who had been removed from parental care.<sup>15</sup> To provide these services, the state established state-run institutions to accommodate these children.

The legislation provided for the establishment of institutions to accommodate ‘neglected children’ and ‘juvenile offenders’.<sup>16</sup> By the 1960s, the types of institutions that the State of Victoria could establish included:

- reception centres for short-term accommodation and maintenance of children admitted to the care of the Department, taken to or placed in these centres under legislation or in respect of whom protection applications were made<sup>17</sup>
- remand centres for the detention of children awaiting trial or sentence, or transit to or from a youth training centre, children’s home or children’s reception centre<sup>18</sup>
- youth training centres for the care and welfare of children committed to detention under legislation or children admitted to the care of the department who, in the Director-General’s opinion, were in need of special supervision, social adjustment or training<sup>19</sup>
- children’s homes for the care and welfare of children admitted to the care of the Department.<sup>20</sup>

Some institutions that the State of Victoria established were multi-functional – they acted as a reception centre, remand centre and youth training centre.

Between the 1950s and the early 1990s, the State of Victoria ran over 30 institutions to care for children and young people,<sup>21</sup> including those of Indigenous background. Indigenous children had a relatively high rate of admission to state care.<sup>22</sup>

The profiles of three of the institutions examined at the public hearing are set out below.

## Placement of residents

### Children in need of care and protection

In 1954, the *Children’s Welfare Act 1954* (Vic) replaced the term ‘neglected child’ with the term ‘child in need of care and protection’.<sup>23</sup> This legislation expanded the reasons to remove a child from parental care to include children who were deemed to be ‘exposed to moral danger’ or ‘likely to lapse into a career of vice or crime’.<sup>24</sup> These were commonly described as ‘status offences’, which did not require proof of criminal behaviour. The Royal Commission heard evidence that status offences were not thought to reflect badly on the parents of the child and were easily substantiated.<sup>25</sup>

The inclusion of these status offences as part of the definition of a ‘child in need of care and protection’ blurred the distinction between those children and juvenile offenders. It also had the effect of drawing into the system children who otherwise would not have been placed in the care of the Department.<sup>26</sup>

The Royal Commission heard evidence that some children were ‘charged’ with committing status offences and brought before the Children’s Court, often with a total absence of legal representation<sup>27</sup> and without the support or presence of parents.<sup>28</sup> The Children’s Court frequently placed children found ‘guilty’ of these status offences in the care of the Department.<sup>29</sup>

Children deemed to be in need of care and protection were ‘admitted’ to the care of the Department and placed under the guardianship of the Director of the Department.<sup>30</sup>

### **Juvenile offenders**

In 1956, the *Children’s Court Act 1956 (Vic)*<sup>31</sup> set out a number of sentencing options for children convicted of a criminal offence. These included detention in a government institution.<sup>32</sup>

Juvenile offenders under the age of 15 could not be sentenced to detention, but they could become wards of the Department and could be ‘committed’ to the care of the Department for up to two years.<sup>33</sup>

Juvenile offenders aged 15 and above could be sentenced to detention for up to two years. They could only become wards of the Department on the basis of a care and protection application, not on the basis of their offending.<sup>34</sup>

### **Separation of children in need of care and protection from juvenile offenders**

Despite the distinction in the legislation between children in need of care and protection and juvenile offenders, between 1954 and the early 1970s there was not always a clear separation of the two groups of children.

Children in need of care and protection could be ‘committed’ to a youth training centre if they were deemed to be in need of ‘special supervision social adjustment and training’,<sup>35</sup> even if they had not committed an offence.

Similarly, a juvenile offender found to be in need of care and protection could be ‘admitted’, rather than committed, to the care of the Department.<sup>36</sup> The legislation also allowed for wards of the Department to be returned to the care of the Department if convicted of an offence.<sup>37</sup>

The Royal Commission heard evidence from both former residents and former staff members that both groups of children were often placed together in the same institution and sometimes in the same section of the institution.

BDB, a former resident of Turana, told the Royal Commission that when she was placed at Turana she was taken to a section of the institution that housed both children deemed to be in need of care and protection and juvenile offenders.<sup>38</sup> BDB gave evidence that, in her view, no efforts were made to separate children in need of care and protection from sentenced juveniles.<sup>39</sup> She said that Turana was 'like a training ground for institutionalisation and gaol'.<sup>40</sup>

Further detail of the placement of residents at the institutions is set out in sections 2 and 4 of this report.

## De-institutionalisation

During the 1970s and 1980s, the number of children who were made wards of the Department declined significantly.

Legislative change in 1978 shifted the focus from child misbehaviour to intervention when a child was maltreated or when the child's guardian had died or was otherwise incapacitated.<sup>41</sup> This reflected a broader shift in thinking about the deficiencies of institutionalisation.<sup>42</sup>

By the mid-1990s, the last of the large children's homes had closed and youth training and reception centres were scaled down, closed or redeveloped.<sup>43</sup>

## 1.2 Role of the Victoria Police

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Victoria Police Assistant Commissioner Stephen Fontana gave evidence about the role of the Victoria Police.

Historically, the Victoria Police had power under legislation to remove a child from parental care if the child was suspected of being in need of care and protection. A protection application could then be made for that child before the Children's Court.<sup>44</sup>

The Victoria Police could also apprehend children suspected of committing a criminal offence and take them before the Children's Court.

The Victoria Police also had powers to apprehend residents of state-run institutions who had absconded.<sup>45</sup> Each state-run institution had a localised arrangement with their local police station to deal with residents that had absconded or committed offences at the institution.<sup>46</sup> Further detail of Victoria Police involvement with residents of youth training and reception centres is set out in section 4 of this report.

## 1.3 Turana Youth Training Centre

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In 1880, the Victorian Government opened an observation, treatment and classification centre for children called the Royal Park Receiving Depot for Girls and Boys.<sup>47</sup> It was located at Parkville in Melbourne, Victoria.

In 1955, that centre was renamed the Turana Youth Training Centre.<sup>48</sup> Turana operated as:

- an assessment and classification centre, which aimed to assess and classify children for placement in a facility appropriate to the child's needs and circumstances
- a residential facility for wards of the Department aged 14 to 17 years who could not be accommodated elsewhere
- a reception centre for children admitted to the care of the Department
- a remand centre for boys aged 10 to 16 charged with an offence or awaiting the hearing of a protection application or similar
- a youth training centre for boys aged 15 to 21 years who had been sentenced to a youth training facility.<sup>49</sup>

Over the period it was in operation, Turana comprised various sections. Each section served a different purpose or catered to a different group of residents. By 1957, Turana had 14 sections with capacity for 265 children and young people.<sup>50</sup>

During the period examined at the public hearing, the sections of Turana included:

- The Gables and Sunnyside, which were open sections designed to get boys ready to return to the community. Each of these sections accommodated between 15 and 20 boys<sup>51</sup>
- Quamby and Coolibah, which were medium-security sections that accommodated both wards of the Department and trainees who were seen to require closer supervision. Each of these sections accommodated approximately 30 boys<sup>52</sup>
- Poplar House, which was a maximum-security section that catered for boys who were deemed emotionally unstable or who presented a serious risk to themselves or the community. It accommodated approximately 28 boys.<sup>53</sup>

Turana was run by a Superintendent, who was responsible for the day-to-day running of the institution. The Superintendent was supported by (in order of seniority):

- a Deputy Superintendent
- a Principal Youth Officer
- Chief Youth Officers
- Senior Youth Officers
- a Night Senior Officer
- Youth Officers.<sup>54</sup>

At times, the Superintendent was also supported by an Assistant Superintendent.<sup>55</sup>

Each section of the institution was staffed by a number of Youth Officers. Youth Officers were supervised by a Senior Youth Officer and overseen by a Chief Youth Officer. These staff were responsible for the day-to-day supervision and care of residents.

In 1993, Turana was closed and the Melbourne Youth Justice Centre opened on the site.<sup>56</sup>

## 1.4 Winlaton Youth Training Centre

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Winlaton began operating at Nunawading in Melbourne, Victoria, in August 1956.<sup>57</sup> It operated as a youth training centre, a classification and assessment facility, a remand centre and a reception centre.<sup>58</sup>

Winlaton was the only statutory institution in Victoria for young women aged between 14 and 21 years, although some girls younger than 14 were admitted to Winlaton. This was because they were deemed to present a severe management problem or because they persistently ran away from non-secure facilities.<sup>59</sup>

Winlaton provided accommodation for up to 45 girls in three sections or cottages.<sup>60</sup> Departmental documents describe that the sections were designed to segregate girls into their various stages of training and to avoid mixing newly admitted girls with girls who had almost completed periods of training.<sup>61</sup>

During the period examined in the public hearing, the sections of Winlaton included:

- Goonyah, which was a maximum-security section for older girls and girls who had been sentenced or were awaiting a court appearance.<sup>62</sup> Goonyah was described as the punishment section of Winlaton<sup>63</sup>
- Karingal, which was an open, medium-security section for girls deemed to have continuing behavioural problems or who had previously had unsuccessful community placements<sup>64</sup>
- Warrina, which was an open, medium-security section that was divided into two sections: newly admitted girls awaiting classification; and classified girls awaiting further placement.<sup>65</sup>

In 1959, two additional sections were established:

- Winbirra – a remand centre<sup>66</sup>
- Leawarra – a hostel that was mainly used as a halfway house for those girls who were employed but were deemed to still require some supervised care.<sup>67</sup>



Like Turana, Winlaton was run by a Superintendent, who was responsible for the day-to-day running of the institution. The Superintendent was supported by (in order of seniority):

- one or two Deputy Superintendents
- a Principal Youth Officer
- Chief Youth Officers
- Senior Youth Officers
- a Night Senior Officer
- Youth Officers.<sup>68</sup>

At times, there was also an Assistant Superintendent.<sup>69</sup>

Each section of the institution was staffed by a number of Youth Officers. Youth Officers were supervised by a Senior Youth Officer and overseen by a Chief Youth Officer. These staff members were responsible for the day-to-day supervision and care of residents.

In September 1991, Winlaton was renamed the Nunawading Youth Residential Service and became a mixed-gender facility.<sup>70</sup> In 1993, it was relocated to the former Baltara site and became known as the Parkville Youth Residential Centre.<sup>71</sup>

## 1.5 Baltara Reception Centre

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Baltara commenced operation in October 1968 on the same campus as Turana.<sup>72</sup>

Baltara was a remand centre designed for boys aged 10 to 15 years.<sup>73</sup> It was also a reception centre for early adolescent male wards of the Department awaiting placement in children's homes.<sup>74</sup>

Initially, Baltara comprised four sections that each accommodated about 20 to 25 boys. A fifth section was added during 1969–1970.<sup>75</sup>

From 1983, Baltara was divided into the following five sections:

- Kinta, which was designed to accommodate up to 20 'older, tougher' boys, including boys convicted of sexual offences<sup>76</sup>
- Mawarra, which was designed to accommodate a mixed group of up to 20 boys<sup>77</sup>
- Warrawong – the only high-security section – which was designed to accommodate up to 20 habitual absconders and serious offenders<sup>78</sup>
- Akora, which was designed to accommodate up to 20 boys who were deemed to be less mature or who had physical or mental disabilities<sup>79</sup>
- The Oaks, which was a house offsite that was designed to house up to five boys who had been convicted or were deemed to have a strong pattern of sex offending.<sup>80</sup>

At Baltara, the most senior position was that of the Manager, who oversaw the entire institution. The Manager was supported by a team of administrative staff known as the 'executive team'. The 'executive team' included:

- Deputy Managers
- Senior Admitting Officers
- a Principal Youth and Child Care Officer (Principal YACCO)
- Senior Youth and Child Care Officers (Senior YACCOs).<sup>81</sup>

Each section was overseen by a Senior YACCO, who, together with Youth and Child Care Officers (YACCOs), were responsible for the day-to-day supervision and care of the boys.<sup>82</sup> Each YACCO also acted as the 'assignment officer' for up to six residents. Assignment officers were required to have detailed knowledge of the background and issues of the residents assigned to them.<sup>83</sup>

In 1991, Baltara was closed and residents were moved into residential and reception units in the community.<sup>84</sup>

## 2 Residents' experiences at Turana, Winlaton and Baltara

The Royal Commission heard evidence from 11 former residents of Turana, Winlaton and Baltara during the public hearing. Written statements from three additional former residents were tendered at the public hearing.

Thirteen survivor witnesses described suffering serious sexual, physical and emotional abuse perpetrated by staff, social workers and other residents while they were at the institutions.

Mr Norman Latham, Mr Joseph Marijancevic, BDB, BDD and Mr Robert Cummings gave evidence about their experiences of sexual and physical abuse while at Turana between 1962 and 1971.

Mr William Clark gave evidence about the sexual and physical abuse he experienced at Baltara in 1971. BDA gave evidence about the sexual abuse he suffered at Baltara in 1988 and also of his experience of sexual and physical abuse at Turana in 1993–1994.

BDC, Ms Gabrielle Short, BHE, Ms Karen Hodgkinson, BHU and BDF gave evidence about their experiences of sexual and physical abuse while at Winlaton between 1963 and 1987.

Another survivor witness, Katherine X, gave evidence about her experience at Winlaton in 1979. Katherine X told the Royal Commission that she was sexually abused by her father from 1977 to 2005. The response of Winlaton and Department staff to her disclosures of sexual abuse perpetrated by her father is considered in section 5.

All survivor witnesses gave evidence about the impact the sexual abuse has had on their lives. A number of survivor witnesses also gave evidence of their recommendations for improvement, including the need for:

- rehabilitation
- education and support<sup>85</sup>
- a consistent social worker for each child.<sup>86</sup>

### 2.1 Early life experiences of survivor witnesses

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A number of survivor witnesses gave evidence that, before they were placed at Turana, Winlaton or Baltara, they had experienced significant trauma or abuse.

Many of the survivor witnesses were placed in residential institutions or placed in departmental care because it had been found that their parents were unable or unwilling to care for them.<sup>87</sup>

Some survivor witnesses suffered sexual abuse before they were taken into the Department's care.<sup>88</sup>

Nine survivor witnesses said that, before being taken into care, they suffered physical and emotional abuse at home.<sup>89</sup> Mr Cummings said that at times his father and his stepmother locked him in his

room and starved him.<sup>90</sup> Mr Marijancevic was admitted to the care of the Department for being 'ill-treated' after a brutal beating by his father.<sup>91</sup>

Some survivor witnesses said that they ran away from home to escape abuse or 'acted out'.<sup>92</sup> This resulted in them being placed in the care of the Department for being deemed 'likely to lapse into a career of vice and crime'<sup>93</sup> or because they were deemed to be 'exposed to moral danger'.<sup>94</sup>

Other survivor witnesses told the Royal Commission that the abuse they suffered at home seriously affected them psychologically. Both BDA and Ms Hodgkinson were admitted to the care of the Department for 'being exposed' following suicide attempts at nine and 14 years of age (respectively).<sup>95</sup>

Many survivor witnesses were placed in other institutions before being sent to Turana, Winlaton or Baltara.<sup>96</sup> Some survivor witnesses said that they experienced sexual and physical abuse at these institutions.<sup>97</sup> Many survivor witnesses were taken to Turana or Winlaton after absconding from other institutions to avoid continued abuse.<sup>98</sup>

By the time many survivor witnesses were placed at Turana, Winlaton or Baltara, they were already extremely vulnerable.

## 2.2 Sexual abuse

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Mr Latham, Mr Marijancevic, BDB, BDD and Mr Clark told the Royal Commission that they were sexually abused by staff members at Turana or Baltara. Colloquially, residents knew and referred to staff members as 'screws'.

BHE and Ms Hodgkinson told the Royal Commission that they were sexually abused by social workers who visited them at Winlaton.

Many survivor witnesses suffered child-to-child sexual abuse. BDB, BDD, Mr Cummings, Mr Clark, BDA, BDC, BHE and BDF told the Royal Commission that they were sexually abused by other older residents at the institutions. Ms Short and BHU also gave evidence that they witnessed older residents sexually abusing younger residents at Winlaton.

### Mr Norman Latham

Mr Latham was sent to Turana in 1962, when he was 15 years old. He gave evidence that, when he arrived at the Quamby section, a senior officer named Mr Douglas Wilkie told him:<sup>99</sup>

While you're here, your arse belongs to us. If you don't do what we say, you'll go to Poplar House and they'll cut your throat down there.

Mr Latham told the Royal Commission that he was raped nine times by Mr Wilkie and 10 times by another senior officer named Mr Eric Horne. He said that on each occasion Mr Wilkie or Mr Horne threatened to send him to Poplar House – the maximum-security section of Turana.<sup>100</sup>

Mr Wilkie was represented at the public hearing. Through his counsel, he denied the allegations of sexual abuse made against him.<sup>101</sup>

Mr Latham gave evidence that the abuse stopped when he left Turana in 1963 at the age of 16.<sup>102</sup>

### Mr Joseph Marijancevic

Mr Marijancevic was placed in Turana briefly in 1961, when he was 11 years old, before being transferred to various boys' homes.<sup>103</sup> In 1965, when Mr Marijancevic was 15 years old, he was transferred back to Turana.<sup>104</sup>

Mr Marijancevic said that when he was 15 years old he was sexually abused on two occasions by officers at Turana.<sup>105</sup> Mr Marijancevic said that the first incident of sexual abuse occurred while he was cleaning the stairs with a toothbrush as punishment. He said an officer named Mr Michael Monaghan directed him to go into a broom closet.<sup>106</sup>

Mr Marijancevic said that he was 'king hit' by Mr Monaghan<sup>107</sup> and that, when he woke up, he was face-down on a bench or table in the broom closet. He said that Mr Monaghan raped him.<sup>108</sup>

Mr Marijancevic gave evidence that the second incident of sexual abuse occurred while he was polishing the floors at Poplar House. He said that an officer told him to come into the office, where he was offered a piece of cake and soft drink.<sup>109</sup> Mr Marijancevic told the Royal Commission that he was told to sit on the officer's knee. He said that the officer then sexually abused him.<sup>110</sup>

### BDB

BDB was raised as a boy but began to identify as a girl from a very young age.<sup>111</sup>

BDB was first admitted to Turana in 1963, when she was 12 years old.<sup>112</sup> She spent time in another children's home before being returned to Turana in 1965, when she was 14 years old.<sup>113</sup>

BDB told the Royal Commission that at Turana she was placed in Classification B – a dormitory with about 20 boys. She said that in this section she was sexually abused repeatedly by an older and larger boy.<sup>114</sup> She said that one night she banged on the door and yelled to go to the toilet to avoid the nightly visit from this boy.<sup>115</sup>

BDB gave evidence that she was escorted out of the dormitory by an officer named 'Mr Jones', who took BDB to the staff tearoom. BDB said that Mr Jones exposed his genitals to her and asked her to touch them.<sup>116</sup>

The Royal Commission heard evidence from BDB that the care she experienced was ‘toxic’ and ‘dangerous’.<sup>117</sup>

## BDD

BDD was placed in Turana in 1965, when he was about 14 years old.<sup>118</sup>

BDD stated that within the first couple of weeks at Turana he was physically abused by three older boys, who also tried to sexually abuse him. He stated that the older boys taunted him by making sexual comments and exposing their penises to him. BDD stated that the assault was ‘quite loud’ and continued for about 30 minutes, but staff did not intervene.<sup>119</sup>

BDD gave evidence that he was also sexually abused by a guard at Turana. He stated that the guard watched him while he showered. On one occasion, the guard rubbed himself and touched BDD on the buttocks as BDD was getting out of the shower.<sup>120</sup>

BDD stated that on one night he woke up to see the guard standing next to his bed with his pants down, ‘playing with himself’.<sup>121</sup> He stated that his sheets had been pulled back and that the guard touched his leg and tried to grope and kiss him. BDD stated that, when he told the guard to go away, the guard said that if BDD told anyone the guard would talk to the ‘big kids’.<sup>122</sup>

## Mr Robert Cummings

Mr Cummings was placed in Turana for a short period in 1970, when he was 15 years old, before being transferred to a non-government institution, Harrison House.<sup>123</sup>

Mr Cummings told the Royal Commission that he experienced physical and repeated sexual abuse at Harrison House, so he ran away and lived on the streets for about two months. He was taken back to Turana in early 1971.<sup>124</sup>

Mr Cummings said that within his first week back at Turana he was sexually abused in his cell by an older boy, who forced him to perform oral sex. He said that, when he reported the abuse to an officer, he was labelled a homosexual. He said that two officers then ‘frog marched’ him to the Royal Park Hospital, where he received ‘aversion therapy’ treatment.<sup>125</sup> The response of the institution and the administration of aversion therapy on Mr Cummings is set out in section 4 of this report.

Mr Cummings said that when the other residents at Turana found out about the treatment he was labelled the ‘bum boy’.<sup>126</sup> He said that he was sexually abused by the other residents, including being raped in the toilet and in a storeroom by a group of four or five boys.<sup>127</sup>

Mr Cummings gave evidence that the abuse stopped when he was transferred to another non-government institution.<sup>128</sup>

## Mr William Clark

Mr Clark was admitted to Baltara in 1970, when he was 12 years old.<sup>129</sup>

Mr Clark gave evidence that at Baltara he was sexually abused by an officer in the toilets and shower block.<sup>130</sup> He stated that the abuse included the officer touching Mr Clark's genitals and making Mr Clark masturbate in front of the other boys.<sup>131</sup> He also stated that the officer rubbed his penis on Mr Clark's backside and on some occasions ejaculated on Mr Clark.<sup>132</sup>

Mr Clark also gave evidence of other residents forcing him to masturbate in front of them.<sup>133</sup>

## BDA

BDA was admitted to Baltara in 1988, when he was 10 years old.<sup>134</sup>

BDA told the Royal Commission that at Baltara he was sexually abused by a group of between eight and 10 residents, who he said looked between 12 and 16 years of age.<sup>135</sup> He said that the residents approached his bed holding their penises in their hands and one of the residents forced BDA to perform oral sex.<sup>136</sup>

BDA was at Baltara for about four months before being returned to his mother.<sup>137</sup>

BDA said that, after spending time on the streets and in various non-government institutions, in 1993 as a 15-year-old he was committed to Turana for stealing.<sup>138</sup> He said that at Turana he was physically and sexually abused by other residents with whom he shared a room. He said that two residents jumped into his bed at night and masturbated him or forced him to masturbate them.<sup>139</sup> He said the abuse continued until he left Turana in 1994.<sup>140</sup>

## BDC

BDC was taken to Winlaton in 1963, when she was 14 years old, after spending time in various government and non-government institutions. She was placed in the Goonyah section at Winlaton.<sup>141</sup>

BDC told the Royal Commission that she was sexually abused by three older residents at Winlaton.<sup>142</sup> She said that the abuse occurred during the day in a locked room that accommodated girls who had not been allocated chores. The room was next to the staff room, separated only by a window.<sup>143</sup>

BDC gave evidence that two of the girls held her down while the other girl inserted her fingers in BDC's vagina.<sup>144</sup> She said that she later saw another girl being abused in a similar way. She said that 'it was part of the culture in Goonyah for girls to abuse each other like this'.<sup>145</sup>

## Ms Gabrielle Short

Ms Short was admitted to Winlaton in 1970, when she was 14 years old.<sup>146</sup>

Ms Short told the Royal Commission that while she was in the Karingal section of Winlaton she witnessed 'gang rapes' committed by residents on other residents on an almost daily basis.<sup>147</sup>

Ms Short recalled that on one occasion, when she was in the Leawarra section, she tried to intervene when three or four residents held down another resident on a bed and inserted the neck of a broken beer bottle into the other resident's vagina. She said that when staff intervened she was too scared to report why she had initiated a fight.<sup>148</sup>

## BHE

BHE was taken to Winlaton in 1971, when she was 15 years old.<sup>149</sup>

BHE told the Royal Commission that within the first few months of arriving at Winlaton she was sexually abused by her allocated social worker, Mr Ross McIntyre.<sup>150</sup> She said that Mr McIntyre pushed her against the wall in an office, kissed her and fondled her breasts under her jumper but on top of her bra.<sup>151</sup>

Mr McIntyre was represented at the public hearing. Through his counsel, he denied the allegations of sexual abuse made against him.<sup>152</sup>

BHE said that she was also sexually abused by other residents in Winlaton.<sup>153</sup> She said that when she was placed in Goonyah an older resident sexually abused her every day for a couple of months. The abuse stopped when the older resident was released from Winlaton.<sup>154</sup> She said that she also witnessed other residents being sexually abused, stating that the sexual abuse 'was everywhere'.<sup>155</sup>

## Ms Karen Hodkinson

Ms Hodkinson was placed at Winlaton in 1974, when she was 14 years old.<sup>156</sup>

Ms Hodkinson gave evidence that while she was at Karingal she was sexually abused by her social worker from the Department, Mr Paul Yew.<sup>157</sup> Ms Hodkinson said that she met with Mr Yew once a week. Initially, she liked him because he brought her gifts and took her on leave.<sup>158</sup> She said that one day Mr Yew told her that he could make things easy for her if she was nice to him. She said that Mr Yew kissed her and touched her on the outside of her underwear.<sup>159</sup>

Ms Hodkinson said that about two weeks later Mr Yew raped her. She said that she was raped by Mr Yew three times and the abuse went on for about three months.<sup>160</sup> Ms Hodkinson said that the abuse stopped when, all of a sudden, Mr Yew stopped visiting her.<sup>161</sup>



## BHU

BHU was first placed in Winlaton in 1974, when she was about 15 years old. She absconded from Winlaton and was taken to another government-run institution before being sent back to Winlaton in 1975. She was about 16 years old at the time.<sup>162</sup>

BHU stated that within about a week and a half of being at Winlaton she witnessed a young girl being taken to the toilets by three older residents. She stated that she saw two of the older residents hold the younger girl's legs while the other older resident pushed the wooden handle of a toilet brush inside the younger girl's vagina.<sup>163</sup>

BHU stated that she tried to stop the abuse and called staff to intervene.<sup>164</sup> She gave evidence that the next day her clothes were torn up as punishment for 'lagging'.<sup>165</sup>

## BDF

BDF was taken to Winlaton in 1987, when she was 14 years old.<sup>166</sup>

BDF gave evidence that she was sexually abused by older residents at Winlaton. She said that one older resident repeatedly jumped in her bed at night and sexually abused her, which involved fondling, penetration and oral sex.<sup>167</sup> The abuse stopped when BDF was removed to another room after reporting that the older resident had suffered a fit.<sup>168</sup>

BDF said that she was also sexually abused during 'movie nights', which were held about once a week. She said that during one movie night, after the lights had been turned off, older residents from the Goonyah section took her to the front of the room, held her down and sexually abused her.<sup>169</sup> BDF said that during movie nights staff members were present in the hall and they should have seen her being taken to the front row.<sup>170</sup>

BDF also gave evidence that she was sexually abused in the yard of Winlaton. She said that on one occasion some older residents pushed her against a wall while another resident penetrated her vagina with her fingers.<sup>171</sup>

## 2.3 Other forms of abuse

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Many survivor witnesses gave evidence that, in addition to being sexually abused at Turana, Winlaton and Baltara, they also experienced other forms of abuse at the institutions.

## Physical abuse

Mr Marijancevic said that at Turana he was ‘king hit’ between the eyes by Mr Monaghan before he was sexually abused.<sup>172</sup> BDB, BDD, Mr Cummings and BDA gave evidence that they were physically abused by other residents at Turana.<sup>173</sup> Mr Cummings said that the ‘screws’ saw him being abused by other residents but did nothing to stop the abuse.<sup>174</sup>

The Royal Commission heard evidence that BDC and Ms Hodgkinson were physically abused by senior staff members at Winlaton. BDC said that the Assistant Superintendent, Miss Summersett, physically abused her on a number of occasions, including by grabbing her by her hair, dragging her through a corridor and flushing her head in the toilet.<sup>175</sup>

Some survivor witnesses said that they experienced or witnessed physical abuse by other residents at Winlaton. BDF gave evidence that on each occasion she was sexually abused at Winlaton she was also physically abused.<sup>176</sup> Ms Short and BHU gave evidence that they witnessed child-to-child physical abuse at Winlaton.<sup>177</sup> Ms Short said that when staff members at Winlaton saw what was going on they took no steps to protect the residents from abuse.<sup>178</sup>

Mr Clark experienced physical abuse at Baltara. He stated that the ‘officers were always punching boys’ noses’.<sup>179</sup>

## Punishment and control

A number of survivor witnesses also gave evidence about the forms of punishment they experienced at the institutions.

### Solitary confinement

On some occasions, residents were placed in solitary confinement as punishment. Mr Cummings and Mr Marijancevic gave evidence that this method of punishment was used at Turana.<sup>180</sup>

Solitary confinement was also used at Winlaton. BDC and Ms Short said that, when they arrived at Winlaton, they were immediately placed in lockup for 48 hours.<sup>181</sup> BDC said that lockup was used regularly as a punishment. On one occasion, after BDC attempted to run away, she was locked in a cell for several weeks.<sup>182</sup>

Dr Lloyd Owen and Dr Eileen Slack, former Superintendents at Winlaton, and Ms Marilyn Minister, former Deputy Superintendent at Winlaton, acknowledged that, during their respective tenures at Winlaton, lockup facilities were used to contain or punish residents.<sup>183</sup> During oral evidence, they each said that at the time they were concerned about lockup being used as a means of punishment rather than as a way of dealing with an immediate crisis.<sup>184</sup>

While Dr Owen and Dr Slack said that the use of lockup decreased during their respective tenures at Winlaton,<sup>185</sup> Ms Minister said that right up until 1992 there was always a cell, or time-out room, that could be used to lock up residents.<sup>186</sup>

### Sanitary care at Winlaton

Some survivor witnesses gave evidence that at Winlaton some staff members controlled and humiliated residents through the provision of sanitary care. BDC and BHU said that when they began menstruating they were given a single pad and they had to show it to staff once it was used before they could get a fresh pad.<sup>187</sup> Similarly, Ms Hodgkinson said she had to put the dirty pad in a brown paper bag to show a staff member.<sup>188</sup>

### Command and control

The Royal Commission heard evidence that at Turana some staff members controlled and punished residents by forcing them to do menial tasks.<sup>189</sup> Mr Marijancevic and Mr Cummings gave evidence that they were forced to scrub brickwork with a toothbrush and polish floors.<sup>190</sup>

Some staff members also made threats of punishment to ensure compliance and to exercise command and control. Mr Latham said that Mr Wilkie and Mr Horne repeatedly used Poplar House as a threat to control his life and daily routine. He said that Mr Wilkie said to him:<sup>191</sup>

While you're here, your arse belongs to us. If you don't do what we say, you'll go to Poplar House and they'll cut your throat down there.

The 'Manual of Instructions for Turana' (Turana Manual) states that punishment is to be minimised and officers must not make threats to any boy.<sup>192</sup> We are satisfied that these forms of punishment were a feature of the culture of the institution; they were not mandated by formal policies or procedures.

We are also satisfied that at Turana the punishments that some staff members inflicted on residents were designed to keep residents occupied and compliant and were an informal mechanism of command and control.<sup>193</sup>

The punishment and methods of control that some staff members used were cruel, dehumanising and degrading.

## Strip searches at Winlaton

During the period that Winlaton was in operation, some residents were subjected to strip searches when they were admitted, returned from leave or returned from absconding.<sup>194</sup>

BDC recalled being made to stand in a line with other residents during a strip search. She said that staff sometimes told her to stand with her legs apart and jump. She said that staff sometimes placed a mirror between her legs to check for contraband.<sup>195</sup>

BHE said she was made to stand over a mirror naked with her legs open and arms out while an officer felt her all over.<sup>196</sup>

Ms Short said that on one occasion a female officer placed her fingers inside Ms Short's vagina to check for hidden items.<sup>197</sup> Ms Short said that, when she objected to being searched, she was told that the male night watchmen would be called to do the search if she did not cooperate.<sup>198</sup>

BHE and BHU said that sometimes male staff performed these searches.<sup>199</sup>

We are satisfied that the strip searches that some residents of Winlaton were subjected to were degrading, humiliating and invasive and residents experienced them as sexually abusive. We consider that there is doubt as to whether most of the strip searches were even necessary.

When questioned about searches at Winlaton, Dr Slack said that she was aware that residents were searched upon admission, but she was not aware that residents were strip searched.<sup>200</sup> She said that she did not attend any searches to see how they were being done.<sup>201</sup>

Ms Minister acknowledged that strip searches were conducted.<sup>202</sup> She said that, although the searches were a breach of the residents' privacy and could be humiliating, degrading, intrusive and uncomfortable, the searches were a necessity.<sup>203</sup> She gave evidence that she never attended a strip search<sup>204</sup> or asked residents about their experiences of the strip search.<sup>205</sup> She accepted that, in the absence of spot checks or an audit process, individual Youth Officers could conduct checks in any manner they wanted.<sup>206</sup>

The Royal Commission was not provided with any policies or procedures of Winlaton concerning strip searches. While the Winlaton policies and procedures manuals (1980 and 1987) refer to searches being conducted on residents when they returned from leave,<sup>207</sup> there were no formal procedures or policies on how strip searches at Winlaton were to be conducted and no oversight by senior staff of strip searches.

### Internal medical examinations at Winlaton

The Winlaton policies and procedures manuals (1980 and 1987) set out procedures for medical treatment. In relation to treatment for venereal diseases, the manuals state that a Government Clinic attended each Wednesday and the nursing sister would arrange appointments for appropriate residents.<sup>208</sup> There is no other information in the manuals on supervision of the treatment, consent or how the treatment was to be conducted.

BDC, Ms Short, BHE and Ms Hodgkinson each gave evidence that these examinations occurred soon after admission and on return from visits or absconding.<sup>209</sup>

BDC said that she was locked in a room and made to put her legs up in stirrups. She said that the doctor 'fiddled around' with her vagina.<sup>210</sup> She recalled that once the examination lasted 35 minutes.<sup>211</sup>

Ms Short and Ms Hodgkinson gave evidence that, despite their pleas that they were both virgins, they were still forced to undergo the examination.<sup>212</sup> Both survivors recalled that they had to be held down while the internal examination was conducted.<sup>213</sup> Ms Short said that when she returned to Winlaton after the first examination her underwear was covered in blood.<sup>214</sup>

BDC said that she was never told why the examination was conducted and she never gave her permission.<sup>215</sup> Similarly, BHE said she was never told why she had to undergo these checks.<sup>216</sup>

Ms Hodgkinson gave evidence that her sexual history was taken at Winlaton before the examination was forced on her,<sup>217</sup> but no-one explained what the examination entailed and she did not give permission for the examination to take place.<sup>218</sup>

Ms Minister said that it was not mandatory for residents to be subjected to intrusive checks to determine if they had a venereal disease.<sup>219</sup> She accepted that it would be completely inappropriate for residents to be forced to undergo an examination and that she would consider it 'assault on the young person'.<sup>220</sup>

We accept that between the 1960s and early 1970s some residents were subjected to internal medical examinations by doctors who attended Winlaton or at a venereal disease clinic in Fitzroy, Victoria. We also accept that the internal medical examinations were intrusive and invasive.

We are satisfied that residents were not told why the examinations were being conducted and that on some occasions the examinations occurred in a questionable manner and without the residents' consent. We accept that the residents experienced these internal examinations as sexually abusive. We consider that there are doubts that many of these examinations were necessary.

## 2.4 Impact of abuse

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All of the survivor witnesses gave evidence of the devastating effect that sexual and other abuse has had on their lives. Many survivor witnesses gave evidence that the abuse they experienced ruined their lives. BHE said: 'What happened to me at Winlaton has ruined my life. I would never want what happened to me to happen to another child.'<sup>221</sup>

Some survivor witnesses, such as BDB, told the Royal Commission that for many years it was difficult to acknowledge the abuse that occurred. BDB said, 'If you asked me when I was 40 whether I'd been abused, I would have told you, no'.<sup>222</sup>

Some survivor witnesses said they suffered drug or alcohol abuse in the past.<sup>223</sup> Many survivor witnesses had experienced mental health problems including depression, anxiety, nightmares and breakdowns.<sup>224</sup> Some reported having attempted or contemplated suicide.<sup>225</sup>

Some survivor witnesses said that, because of their mental health problems or the lack of education and training they received at the institutions, they had difficulty finding and maintaining jobs.<sup>226</sup>

Many of the survivor witnesses gave evidence that they had problems with intimacy and were distrustful of others.<sup>227</sup> Some survivor witnesses expressed regret that they were deprived of the opportunity to form relationships with siblings and other family members.<sup>228</sup> Others said that their experiences impacted upon their ability to care for their children or made them overly cautious and protective parents.<sup>229</sup>

Survivor witnesses who had undergone internal medical examinations at Winlaton said that they were fearful, uncomfortable or resentful around medical professionals.<sup>230</sup>

## 3 Reporting of child sexual abuse at Turana, Winlaton and Baltara

### 3.1 Disclosures of child sexual abuse

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A number of survivor witnesses gave evidence that they disclosed the sexual abuse they experienced to staff members and the Victoria Police. For many survivor witnesses who reported abuse, the immediate response to their disclosures of abuse was physical punishment or not being believed.

#### Physical punishment for reporting sexual abuse

Ms Hodgkinson said that when she reported sexual abuse perpetrated by her social worker, Mr Yew, to an officer at Winlaton named Ms Baxter, Ms Baxter slapped her across the face.<sup>231</sup>

BHU and BHE gave evidence that, when they reported the sexual abuse perpetrated by other residents, they were punished by other residents for 'lagging'.<sup>232</sup> BHE said that, on one occasion where she 'lagged', she had a blanket placed over her head and was beaten by other residents.<sup>233</sup>

As discussed in section 4 below, Mr Latham and Mr Marijancevic gave evidence that they were physically punished by the Victoria Police for reporting sexual abuse when they absconded.<sup>234</sup>

#### Victims not believed or accused of telling lies

BHE told the Royal Commission that, when staff became aware of her allegation that her social worker, Mr McIntyre, had sexually abused her, a staff member told her that she was lying and that Mr McIntyre was a 'lovely person'.<sup>235</sup>

Ms Hodgkinson said that, when she reported the sexual abuse by Mr Yew to Ms Baxter, Ms Baxter slapped her and said:<sup>236</sup>

How dare you make up such dirty lies about one of my staff members. You are nothing but a dirty little lying bitch. Girls like you are why we have places like this, because you need to be taught to tell the truth.

BDA said that, when he reported sexual abuse by other residents to staff at Turana, he was made to feel like he was the instigator and not the victim. This discouraged him from reporting further abuse.<sup>237</sup>

Mr Cummings said that, when he reported sexual abuse by other residents to an officer at Turana, he was told it was only happening because of Mr Cummings' 'homosexuality' and that he needed to be cured.<sup>238</sup> He said that he made further disclosures of sexual abuse and he was not believed, and this discouraged him from making further disclosures.<sup>239</sup> The response of Turana and the Department to Mr Cummings' disclosures of child sexual abuse is set out in further detail in section 4 of this report.

## Solitary confinement and isolation

Ms Hodgkinson said that, when she first reported the sexual abuse by Mr Yew to Ms Baxter, Ms Baxter took her to Goonyah and locked her up for a few days. She said she was given only a blanket in a room with no bed.<sup>240</sup> When she tried to disclose the abuse to Ms Baxter again, Ms Baxter said that if she continued to lie she would be locked up in Goonyah.<sup>241</sup> This discouraged Ms Hodgkinson from disclosing further abuse.<sup>242</sup>

Mr Marijancevic said that, after Mr Monaghan sexually abused him, he was taken to an isolation cell and called a 'dirty little pig'.<sup>243</sup> He said that Mr Ian Cox, the then Superintendent, visited him in the isolation cell.<sup>244</sup> He said that he told Mr Cox that 'the screw [Mr Monaghan] hit me and hurt me'.<sup>245</sup> Mr Marijancevic said that Mr Cox's response was to keep him in the isolation cell overnight.<sup>246</sup>

## Residents not informed of action taken

BDD gave evidence that when he reported the sexual abuse by a staff member to the head of Quamby, Mr Aldridge, he recalled notes being taken and being asked whether what he was saying was true.<sup>247</sup> Although he could not recall Mr Aldridge's response, he said that he never saw the staff member again.<sup>248</sup>

## Conclusion

We accept that some residents who reported sexual or physical abuse to a staff member were punished, not believed or were not informed of action to be taken. This discouraged residents from disclosing further incidents of sexual abuse.

## 3.2 Reasons for not reporting child sexual abuse

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Some survivor witnesses told the Royal Commission that they did not report sexual abuse they suffered at the time it was occurring for one or some of the following reasons.

### Fear of punishment by staff

Mr Latham told the Royal Commission that he feared that, if he reported the sexual abuse perpetrated by Mr Wilkie and Mr Horne to other staff members, Mr Wilkie and Mr Horne would find out, as they were the senior officers of the Quamby section. He said that he was scared of Mr Wilkie and Mr Horne because they had the power to take him to Poplar House.<sup>249</sup>

Mr Marijancevic, Mr Cummings, Ms Hodgkinson and BHE gave evidence that, because they had been punished by staff members for reporting earlier incidents of sexual abuse, they did not report



further incidents of sexual abuse because they were scared of being punished again.<sup>250</sup>

Ms Minister gave evidence that some staff members at Winlaton were aggressive towards residents. She said that this contributed to an environment where residents did not feel comfortable disclosing sexual abuse to staff members.<sup>251</sup>

### Fear of being labelled a ‘lagger’ or ‘dobber’

BHE, BDF, Ms Short, BDB and BDA gave evidence that they did not report sexual abuse by other residents because they feared retribution from other residents and being labelled a ‘lagger’ or ‘dobber’.<sup>252</sup>

BHE said that she was too scared to report sexual abuse because she feared repercussions from other residents.<sup>253</sup> BDF said that this culture of punishing anyone who ‘lagged’ or ‘dobbed’ was reinforced by the adult supervisors working at Winlaton.<sup>254</sup>

Ms Short said:<sup>255</sup>

No one was punished because no one had said anything [about child-to-child abuse]. You just didn’t dob people in; you would get a bashing up or, worse, be raped. It was all about surviving in those institutions.

BDB and BDA gave similar evidence about their experiences at Turana and Baltara.<sup>256</sup> BDB feared retribution from other residents if she reported.<sup>257</sup> BDA said that he did not report abuse at Baltara because he was scared of the other boys.<sup>258</sup>

Former staff from Winlaton, Turana and Baltara acknowledged that there was a culture among residents of punishing other residents that ‘lagged’ or ‘dobbed’, which discouraged reporting.<sup>259</sup> Mr David Green, former Superintendent at Turana, and Mr Grant Holland, former YACCO at Baltara, said that residents at Turana and Baltara would not have felt confident that staff could protect them from further physical or sexual abuse if they reported.<sup>260</sup>

### Fear of not being believed

Mr Cummings, Mr Marijancevic, Ms Short, BHE and Mr Clark gave evidence that they did not report sexual abuse because when they had reported sexual abuse in the past they had not been believed.<sup>261</sup>

Mr Marijancevic said:<sup>262</sup>

[I]n the past, all the people I reported to who held positions of authority didn’t believe me, nothing would change this time.

Mr Clark recalled that, when he initially reported sexual abuse at Baltara to a social worker, the social worker took notes but nothing ever happened. He said that he 'just gave up after that point'.<sup>263</sup>

Ms Short said that she did not report the abuse she suffered or witnessed at Winlaton because every time she tried to complain it fell on deaf ears.<sup>264</sup> Similarly, BDC said that she felt that her counsellor or social worker never listened to what she had to say.<sup>265</sup>

Dr Owen said that it was possible that the attitude at the time was that residents were not to be believed and that staff were to be trusted more than residents.<sup>266</sup> He accepted that in that environment some residents would never report being sexually abused by a staff member because they believed that was the reception they were going to receive.<sup>267</sup>

Mr Holland said that during his employment at Baltara it was 'very hard to get admissions' of child sexual abuse from residents. He attributed this to residents feeling powerless and believing that nothing would be done.<sup>268</sup>

### Not knowing to whom to report

Both Mr Cummings and BDA gave evidence that they did not report sexual abuse they experienced while under the care of the Department because they did not know to whom to report.<sup>269</sup> Mr Cummings said that he was not assigned a youth worker and had no contact with any staff members at Turana or the Department.<sup>270</sup>

From the 1960s, the Department began to employ social workers to work with children in care and their families.<sup>271</sup>

BDC gave evidence that while she was at Winlaton a counsellor or social worker visited her every month or six weeks, but she did not listen to what BDC had to say.<sup>272</sup> BDC could not recall whether she reported the sexual abuse, but she said that she 'didn't know what to say or how to say it'.<sup>273</sup>

BDA gave evidence that he met regularly with social workers in the late 1980s, but he did not report the sexual abuse he suffered at Baltara or while living on the streets because he did not feel safe and because his social worker kept changing.<sup>274</sup> He spoke about the need for social workers and other allocated workers from the Department to really engage with the children in the institution and not just focus on when, or if, the child will return home.<sup>275</sup>

Mr Ashley Cadd, a former Youth Officer at Turana, gave evidence that many of the social workers that visited residents at Turana were unable to connect with the residents because they came from such different social backgrounds.<sup>276</sup> Mr Holland said that social workers visited residents at Baltara infrequently and sporadically.<sup>277</sup>

Mr Cadd said that on some occasions the reports that social workers prepared for consideration at classification meetings were not based on a legitimate assessment of the particular child's needs. He said that, instead, they appeared to be copies of reports for other children or fabrications.<sup>278</sup>

The Royal Commission heard evidence that heavy case loads and 'gross under-resourcing' made it difficult for social workers to visit residents regularly.<sup>279</sup>

We are satisfied that the Department's employment of social workers from the 1960s did not prevent, or facilitate the reporting of, child sexual abuse because:

- some residents did not know their allocated social worker
- some residents were not visited by their allocated social worker or were visited infrequently
- some social workers did not foster a relationship or environment in which residents felt comfortable reporting sexual abuse
- social workers were not trained to prevent or facilitate the reporting of sexual abuse of residents.

We accept that some former residents did not report the sexual abuse they suffered because they feared punishment or retribution from other residents. We also accept that some former residents did not report being sexually abused because they did not think they would be believed or did not know to whom to make a report.

## 4 Responses to child sexual abuse at Turana, Winlaton and Baltara

During the public hearing, the Royal Commission heard evidence from seven former staff members (including former Superintendents, Deputy Superintendents and Youth Officers) about the response to child sexual abuse at Turana, Winlaton and Baltara. The following staff members gave evidence:

- Mr Cadd, Youth Officer at Turana between 1968 and 1990
- Mr Green, Assistant Superintendent at Turana in 1965 and Superintendent at Turana between 1968 and 1970
- Ms Minister, Assistant Superintendent and Deputy Superintendent at Winlaton from 1974 to 1992
- Dr Owen, Superintendent at Winlaton from 1974 to 1978
- Dr Slack, Deputy Superintendent at Winlaton from 1976 to 1978 and Superintendent at Winlaton from 1979 to 1991
- Mr Brian Fitzgerald, YACCO at Baltara from 1970 to 1978
- Mr Holland, YACCO at Baltara in 1983 and Senior YACCO at Baltara until the early 1990s.

These former staff members gave evidence on a number of factors at the institutions that contributed to the response (or lack of response) of staff members to reports of sexual abuse. These factors are discussed below.

### 4.1 The institutional environment

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#### Culture at the institutions

The Royal Commission heard evidence from former staff members about the culture at the institutions for caring for residents and for receiving and responding to complaints of sexual abuse.

As outlined above, some survivor witnesses told the Royal Commission that when they reported sexual abuse to staff members they were physically punished, placed in solitary confinement or not believed. Other survivor witnesses said that they did not report the sexual abuse they experienced for fear of being punished or not being believed.

Some former residents gave evidence that at the institutions they felt that staff members treated them like ‘boxes of biscuits ... in a warehouse’,<sup>280</sup> ‘looked after much the same way as you would look after car parts’.<sup>281</sup>

Mr Green gave evidence that, when he commenced in Turana in 1965, he learnt that the method of looking after residents involved a fair amount of authoritarian control and command.<sup>282</sup> Mr Cadd said that the focus was on control, not on the welfare of residents.<sup>283</sup>

Dr Owen gave evidence that at Winlaton in the 1970s the environment was ‘containing, controlling and putting things on hold until [the residents] grew up and hopefully grew out of it, or found some other way of coping’.<sup>284</sup> He said:<sup>285</sup>

[T]he way in which things were delivered down the system, they were the people who were often given up on or not given access or excluded, rather than staying with them and their issues, which is often very, very difficult in order to see them through to the degree that we need to see them through.

Similarly, Mr Holland gave evidence of Baltara being an ‘old-school’ system of brutal care.<sup>286</sup> He said that he felt there was a ‘basic breach of the residents’ human rights’ and stated, ‘There was often no respect for the boys in a humane sense and I think that this lack of respect led to, and allowed, systemic abuse in this institution’.<sup>287</sup>

### Knowledge and awareness of child sexual abuse

A number of former staff members gave evidence of the knowledge and awareness they had of child sexual abuse at the time the institutions were in operation.

Mr Cadd said that as a Youth Officer at Turana in the late 1960s and early 1970s he was unaware of child sexual abuse perpetrated by staff members but recalled an occasion when a resident sexually abused another resident.<sup>288</sup> Mr Green said that, although he was aware of the risk of residents sexually abusing each other when he was Superintendent at Turana, his ‘level of appreciation of the possibility of sexual abuse in 1970 was not as great as it is now or should have been at the time’.<sup>289</sup>

Dr Owen also said that when he was the Superintendent of Winlaton between 1974 and 1978 there was insufficient awareness of child sexual abuse.<sup>290</sup>

Dr Slack and Ms Minister gave evidence that when they worked at Winlaton they were aware of the possibility of residents sexually abusing each other.<sup>291</sup> Dr Slack also contemplated the risk of staff members at Winlaton sexually abusing residents,<sup>292</sup> but Ms Minister did not consider this as a possibility.<sup>293</sup>

Ms Minister gave evidence that it was a ‘fairly common occurrence’ for residents to have been sexually abused before they were admitted.<sup>294</sup> She estimated that there would have been ‘hundreds’ of residents suspected of being victims of sexual abuse perpetrated by a family member.<sup>295</sup>

Mr Holland said that by the 1980s and early 1990s staff members at Baltara were more aware of the problem of child sexual abuse.<sup>296</sup> He said that incidents of sexual and physical abuse between residents occurred on a weekly basis.<sup>297</sup> He was also aware of allegations of physical and sexual abuse perpetrated against residents by staff of Baltara.<sup>298</sup>

We accept that during the time the institutions were in operation, and particularly between the 1960s and 1970s, staff members of Turana, Winlaton and Baltara had limited knowledge and awareness of child sexual abuse.

## 4.2 Policies and procedures for complaints of child sexual abuse before the 1990s

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The Royal Commission heard evidence that before the 1980s the supervising Department did not have policies or procedures for receiving and responding to complaints of child sexual abuse.<sup>299</sup>

In the absence of policies provided by the Department,<sup>300</sup> or instructions from the Department to assist institutional staff members,<sup>301</sup> some institutions developed their own written policies on their operations. The Royal Commission was provided with documents containing policies and procedures that applied at Turana, Winlaton and Baltara.

### Policies and procedures at Turana and Baltara

#### Turana

A document entitled 'Manual of Instructions for Turana' (Turana Manual) contained policies and procedures that applied at Turana from the late 1960s to the mid-1980s.<sup>302</sup> In the mid-1980s, the Turana Manual was revised and an updated manual was created.<sup>303</sup>

The Turana Manual included policies and procedures for:

- night-time supervision of residents<sup>304</sup>
- dealing with residents who had absconded<sup>305</sup>
- discipline and correction<sup>306</sup>
- reports and report writing.<sup>307</sup>

The Turana Manual required officers to complete written reports for 'unnatural acts' but did not define that term. There was no reference to sexual abuse in the Turana Manual. The Turana Manual did not inform officers about how to deal with or respond to incidents involving 'unnatural acts' other than to write a report.<sup>308</sup> Mr Cadd said that officers were given no training on how to apply or interpret the policies in the Turana Manual.<sup>309</sup>

Mr Cadd said that after the Turana Manual was revised in the 1980s there was still no written policy for handling or responding to child sexual abuse.<sup>310</sup> He said that the revised manual removed the reference to 'unnatural acts' and placed greater focus on physical incidents.<sup>311</sup>

The written policies and procedures at Turana did not make any reference to risks of sexual abuse of children in the institution or how to respond to these risks or actual complaints of sexual abuse.

## Baltara

The Department could not locate policies and procedures for Baltara, despite evidence that a manual of instructions for Baltara, similar to that for Turana, appeared to have been created.<sup>312</sup>

The documents that were provided to the Royal Commission that comprised some of the policies and procedures for Baltara did not refer to risks of sexual abuse to children or how to respond to these risks or actual complaints of sexual abuse.

### Development of informal procedures for reports of child sexual abuse

In the absence of formal policies at Turana and Baltara for responding to reports of child sexual abuse, the Royal Commission heard that some former employees at Turana and Baltara developed their own practices and procedures.

Mr Cadd gave evidence that the process he applied for responding to reports of sexual abuse involved escalating reports of sexual abuse to senior officers at Turana.<sup>313</sup> He said by the mid-1980s his process also included reporting incidents to the police (upon consultation with the Principal Youth Officer and the Superintendent) and referring the complainant for a psychiatric assessment.<sup>314</sup>

Mr Holland said that at Baltara YACCOs were required to complete an incident report if they received a complaint or witnessed an incident of sexual abuse of a resident.<sup>315</sup> This report was handed to the Senior YACCO, who made comments and submitted it to more senior members.<sup>316</sup>

Mr Holland gave evidence that, even if reports were submitted to senior members at Baltara, there was no coordinated or systematic response to incident reports. He said that on some occasions residents were moved to different sections and on other occasions there was no response.<sup>317</sup>

We are satisfied that there were no formal policies or procedures in place at Turana or Baltara for receiving or responding to complaints of child sexual abuse.

### Policies and procedures at Winlaton

At Winlaton, a document entitled 'Manual of Instructions for Winlaton Youth Training Centre', dated 'August 1974, Revised 1980' (1980 Winlaton Manual) set out the policies and procedures that applied between 1980 and 1987.<sup>318</sup> Although the 1980 Winlaton Manual made reference to a date of August 1974, the Royal Commission was not provided with a manual that applied in 1974.

The 1980 Winlaton Manual was replaced in 1987 by the 'Winlaton Manual of Guidelines/Procedures, 1987 ed' (1987 Revised Winlaton Manual).<sup>319</sup>

The two manuals included policies and procedures for the operation of Winlaton, including:

- dealing with residents who had absconded<sup>320</sup>
- grievance and serious incident hearings<sup>321</sup>
- searches<sup>322</sup>
- medical examinations<sup>323</sup>
- day and weekend leave.<sup>324</sup>

Dr Owen said that before the 1980 Winlaton Manual the policies at Winlaton did not set out how to handle incidents of sexual abuse. He said that sexual abuse was not clearly defined or considered to be of great significance when he was the Superintendent of Winlaton.<sup>325</sup>

We are satisfied that before the 1980s there were no formal policies or procedures in place at Winlaton for receiving or responding to complaints of child sexual abuse.

### **Development of policies for complaints of child sexual abuse**

Dr Slack said that, when she was appointed Superintendent of Winlaton in 1979, she developed guidelines and procedures for ‘grievance hearings’ and ‘serious incident hearings’,<sup>326</sup> which were introduced in the 1980 Winlaton Manual.

A ‘grievance hearing’, involving the Deputy Superintendent and the Superintendent, was held in the event of a ‘major offence’.<sup>327</sup> The 1980 Winlaton Manual defined a ‘major offence’ to include ‘assault on staff by a girl’ and ‘setting a fire’.<sup>328</sup> After a grievance hearing, any decisions or consequences were recorded. If charges were pressed, a court report was prepared.<sup>329</sup>

‘Serious incidents’ were dealt with by way of a ‘serious incident hearing’, managed by a Chief Youth Officer and Youth Officers.<sup>330</sup> The 1980 Winlaton Manual defined ‘serious incident’ to include ‘sexual assault’.<sup>331</sup> It does not specifically contemplate the sexual abuse of a resident perpetrated by staff.

Between 1980 and 1987, the policies and procedures for responding to sexual assault at Winlaton did not consider sexual assault to be a ‘major offence’. Rather, sexual assault was viewed as a ‘serious incident’ that did not have to be reported to the Principal Youth Officer, Deputy Superintendents or Superintendent.

When the 1980 Winlaton Manual was revised in 1987, Dr Slack said that she set out to develop a procedure for dealing with sexual abuse,<sup>332</sup> as she identified ‘there was something missing’ from the 1980 Winlaton Manual.<sup>333</sup> Ms Minister said that, by that stage, there was clear recognition that sexual assaults within Winlaton were occurring or could have occurred.<sup>334</sup>

The 1987 Revised Winlaton Manual provides that all allegations of sexual assault had to be reported to the Manager (Superintendent), who held a preliminary hearing to determine the seriousness of the allegation and the appropriate type of hearing.<sup>335</sup> This policy was not examined in detail at the public hearing.



## Development of departmental policies during the 1980s

During the 1980s to early 1990s, the Department developed a number of policies on sexual abuse allegations. Counsel for the State of Victoria submitted that, while the policies were not institution-specific, they would have applied to Turana, Winlaton and Baltara.<sup>336</sup>

Although the policies that the Department created in the 1980s dealt with allegations of child sexual abuse,<sup>337</sup> the policies were not adequate for receiving and responding to complaints of child sexual abuse because they did not provide clear guidance to staff members on the action that should be taken.

### 4.3 Recruitment and training of staff to respond to reports of child sexual abuse

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#### Recruitment

Mr Cadd gave evidence that the Department recruited staff who were not equipped to care for children and retained some staff who were only interested in having an easy day, 'to keep the section exactly as it was supposed to be and not make any innovations'.<sup>338</sup>

Mr Cadd gave evidence that during the 1960s and 1970s the staff recruited at Turana were big men; ex-army and ex-policemen.<sup>339</sup> He recalled Mr Horne, a Chief Youth Officer, as a 'very imposing man, a very stern man, and you always had the feeling that, if you didn't do what you were told, then you were going to get it'.<sup>340</sup>

Mr Holland said that at Baltara the Department recruited a staff member from the United States who was later found to have criminal convictions for sexual offences against children in the United States. He said that, although staff members immediately raised concerns about this staff member's interactions with residents, it was not until a police check was completed many months later that the staff member was removed.<sup>341</sup>

The policies and procedures provided to the Royal Commission did not include any procedures for or checks when recruiting staff at the institutions.

We are satisfied that there were no checks to ensure that staff members were not only equipped to care for children but also not a risk to the children. The recruitment practices at the institutions created an environment that was overwhelming for particularly vulnerable children and illustrates serious problems with the recruitment of staff members at the institutions.

## Training

A number of former staff members of Turana and Baltara gave evidence that, when they commenced employment at the institutions, they:

- had no expertise or qualifications
- received no training in working with children or recognising and responding to the risk of child sexual abuse.<sup>342</sup>

Both senior and junior staff said that when they commenced employment at Turana, Winlaton or Baltara they did not feel adequately trained or equipped to deal with the situation they found themselves in.<sup>343</sup> Mr Green said that when he took on the role of Superintendent of Turana he had no management training and was not fully equipped to manage and oversee a large institution.<sup>344</sup>

Some former staff members of Turana and Winlaton told the Royal Commission that they did not participate in any training provided by the Department and the Department did not encourage them to attend training during their employment.<sup>345</sup>

Other former staff members of Turana and Baltara said that training courses did not teach them how to recognise the risk of sexual abuse of residents or respond to complaints of sexual abuse of residents.<sup>346</sup> Mr Holland said that, during some of the training courses he attended, child sexual abuse was discussed in a way that was cursory, upsetting and inaccurate.<sup>347</sup> Mr Cadd described a course he attended as a 'Mickey Mouse course'.<sup>348</sup>

We are satisfied that a lack of adequate training undermined staff members' capacity to recognise the risk of sexual abuse of residents in the institutions by other residents and by staff in the institutions and to respond effectively to complaints of sexual abuse of residents.

## 4.4 Placement of residents

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The Royal Commission heard evidence that at the institutions children who were admitted as wards of the Department were not always kept separate from children committed for criminal offences.<sup>349</sup> Similarly, younger children were placed in sections with older children.<sup>350</sup> Some survivor witnesses gave evidence that in these settings they experienced sexual abuse by residents.

Decisions about the care and management of residents, including where they were to be placed within each institution, were made at classification meetings. These meetings were attended by senior staff members of each institution.<sup>351</sup>

Mr Green gave evidence that, although efforts were made to separate residents of different legal status at Turana, this was not always possible. He said that, when a boy who had been 'admitted' to the care of the Department had to be held securely, he was placed with boys that were 'committed' to the care of the Department for committing a criminal offence.<sup>352</sup>

Mr Cadd said that, when Turana was overcrowded, residents were placed in sections that they would not normally be classified into because there was no room for them elsewhere.<sup>353</sup> The issue of overcrowding at the institutions is discussed further below.

Mr Holland said that at Baltara it was not always possible to appropriately place residents who had offended or were the victims of sexual abuse.<sup>354</sup> Also, it could not be ensured that every child with a mental or physical disability was placed in Akora (the section intended for children with disability).<sup>355</sup> Mr Holland said that in reality there were vulnerable children in every unit.<sup>356</sup>

We are satisfied that the placement and interaction of children admitted as wards of the Department with children committed as juvenile offenders, and of older children with younger children, increased the risk of child-to-child sexual abuse.<sup>357</sup>

## 4.5 Supervision of residents

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A number of survivor witnesses gave evidence about the supervision they received at the time they experienced child sexual abuse.

BDB and BDF were both sexually abused by other residents at night in their dormitories.<sup>358</sup> BDB gave evidence that the dormitory she was in at Turana housed 20 residents and staff could only see in through a small peephole.<sup>359</sup> She said that she had to bang on the door and yell so that she could be let out by the officer on duty.<sup>360</sup>

BDA said that at Baltara the staff office was some distance down the hallway from his dormitory.<sup>361</sup> He said that, on the night he was sexually abused by older residents, the night officer did not check his dormitory.<sup>362</sup> A contemporaneous report states that the position of the dormitory meant that residents could hear staff approaching.<sup>363</sup>

Some survivor witnesses were sexually abused out of sight of staff members or in areas not easily supervised by staff members, such as a broom closet,<sup>364</sup> storeroom<sup>365</sup> or yard.<sup>366</sup>

BDC said that sexual abuse by other residents at Winlaton occurred outside the view of any staff member even though it took place in a room adjacent to the staff room and visible through a window.<sup>367</sup> BHE said that, when she was being sexually abused by another resident in Goonyah, only three staff members were supervising the residents and half the time they were in their office.<sup>368</sup>

### Policies and procedures about supervision

The Turana Manual sets out the responsibilities of night staff at Turana. It states that the night shift officer must inspect each bedroom every half-hour. It also states that the Night Senior Officer must regularly tour the institution, write reports on any occurrences and conduct spot checks.<sup>369</sup>

Although the Royal Commission was not provided with any policies about supervision at Winlaton or Baltara, former staff members of Winlaton and Baltara gave evidence that similar night supervision procedures applied at those institutions.<sup>370</sup>

Mr Green gave evidence that at Turana residents were locked in dormitories at night to sleep.<sup>371</sup> Mr Cadd said that, in practice, all boys were in bed by 9 pm each night and staff were instructed not to turn on bedroom lights or open the doors when conducting spot checks.<sup>372</sup> Ms Minister gave evidence that at Winlaton residents were also locked in their rooms and had to knock on the door and call out to get the attention of the night staff.<sup>373</sup>

The documents provided to the Royal Commission did not set out the policies and procedures for supervision of residents during the day.

## Staffing levels

At all three institutions, each section or unit was supervised overnight by a single night shift officer, while one Night Senior Officer oversaw the entire institution.<sup>374</sup> As discussed above, some sections of the institutions accommodated approximately 15 to 30 residents.

Mr Green said that he was aware that supervision at night and the 'lack of staff' at night was a problem. For example, if there was a medical emergency and a staff member was required to accompany a resident to hospital, this left the institution short-staffed.<sup>375</sup>

The Department was aware that supervision was a problem. Mr Green and Dr Slack gave evidence that they raised their concerns about insufficient numbers of staff at Turana and Winlaton (respectively) with the Department. Mr Green said that the departmental response was that it was a matter of 'budget processes'.<sup>376</sup> He said that it was his understanding that the Superintendent had to manage the running of the institution, including staffing, within the resources allocated by the Department.<sup>377</sup> Dr Slack said that her requests for additional staff were not heard.<sup>378</sup>

We are satisfied that the number of staff members on duty at night at Turana, Winlaton and Baltara was insufficient to provide adequate supervision.<sup>379</sup>

## Physical environment of the institutions

Mr Green said that a lack of alternative arrangements at Turana meant that staff had no option but to lock boys in dormitories to sleep, despite the known risk of child-to-child sexual abuse.<sup>380</sup> He said that he had to trust in the integrity of the night officers.<sup>381</sup> Mr Cadd gave evidence that night-time checks at Turana were conducted through a small observation slit in the doors of the bedrooms.<sup>382</sup>

Ms Minister said that at Winlaton the narrowness of the passages and the layout of the rooms meant that residents could be obscured from the view of staff.<sup>383</sup> Dr Owen agreed that the layout of Winlaton meant that there were places hidden from the view of staff members.<sup>384</sup>

Mr Holland said that at Baltara the layout of bedrooms along a hallway meant that the officer on duty did not have a view of all the bedrooms from the office and residents could hear when officers were approaching.<sup>385</sup> He stated that the structure of the institution made it impossible to provide effective and full supervision.<sup>386</sup>

We are satisfied that the physical environments of Turana, Winlaton and Baltara made it difficult to provide effective supervision.

## Overcrowding

Mr Cadd said that, when Turana was overcrowded, residents were placed in sections that they would not normally be classified into because there was no room for them elsewhere.<sup>387</sup> Residents were also sometimes transferred between sections to alleviate overcrowding.<sup>388</sup>

Mr Cadd described overcrowding at Turana as an 'impossible situation'. He said that on occasions there were four or five boys in a room designed for two, and the room could only be checked through a small observation slit.<sup>389</sup> Mr Cadd said that, as the number of residents increased, there was no change to staff numbers.<sup>390</sup> Overcrowding also made it difficult for staff to get to know the residents.<sup>391</sup>

The Department was aware that overcrowding was a problem at the institutions. Mr Green gave evidence that he told the Department that overcrowding was a key problem. He stated that the 'favoured direction for these problems was to create more alternatives to incarceration than extend the facilities at Turana'.<sup>392</sup>

We accept that overcrowding was a serious problem at Turana, Winlaton and Baltara and hindered the provision of adequate supervision.<sup>393</sup> We are satisfied that, when the institutions were overcrowded, residents were placed in sections based on the availability of beds<sup>394</sup> and not compatibility, suitability and safety.

## Conclusion

For the reasons set out above, we are satisfied that the supervision of residents was inadequate to keep them safe from sexual abuse, particularly at night.<sup>395</sup>

## 4.6 Communication of reports of child sexual abuse within the institutions

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At the institutions, orders concerning the operation of the institutions were passed down by senior staff members to junior staff members. Junior staff members reported to their immediate supervisor, who reported to more senior staff members. The staffing structure at Turana, Winlaton and Baltara fostered a strict chain of command.<sup>396</sup>

Mid-level staff members (Senior Youth Officers, Senior YACCOs and Chief Youth Officers) were also responsible for reporting incidents to the Superintendent and other executive staff.<sup>397</sup> Mr Cadd said that at Turana ultimately it came down to the Senior Youth Officer in the section and what the Senior Youth Officer wanted the Youth Officers to do.<sup>398</sup>

Ms Minister gave evidence that senior management at Winlaton relied on Chief Youth Officers to report any allegations of sexual abuse up the chain of command.<sup>399</sup> She said that these reports would be recorded and noted on the resident's file.<sup>400</sup>

Mr Green said that as Superintendent of Turana he had an expectation that, if a report of sexual abuse of a resident was made, the Chief Youth Officer or Senior Youth Officer would contact the medical officer and make other arrangements to look after the welfare of the resident.<sup>401</sup>

Mr Cadd said that at Turana incidents reported by Youth Officers could get 'lost in the bureaucracy' and that Chief Youth Officers and the Principal Youth Officer could withhold information from the Superintendent.<sup>402</sup> He described the reporting structure of Turana as a 'sieve'.<sup>403</sup> He said that in the 1960s and 1970s the Superintendent and Deputy Superintendent had very little direct contact with residents and their authority was often used by junior staff members as a threat to control the behaviour of residents.<sup>404</sup>

Mr Holland gave evidence that at Baltara it was not uncommon for a Senior YACCO to instruct a YACCO to either not submit an incident report or report that the incident was less serious than it was.<sup>405</sup> He said that incident reports were seen to reflect badly on, and had career consequences for, the Senior YACCO responsible for the section.<sup>406</sup> He said that allegations of sexual abuse of a resident were sometimes 'watered down' and described as sexual experimentation.<sup>407</sup> Similarly, Mr Cadd said that at Turana a complaint could be made to look worse than it was or made to look trivial.<sup>408</sup>

Mr Holland said that YACCOs were discouraged from deviating from the chain of command.<sup>409</sup> He said that staff who did not adhere to the reporting hierarchy or repeatedly raised issues were ostracised, transferred, allocated less desirable shifts, not promoted or pressured to leave.<sup>410</sup>

We are satisfied that, in practice, mid-level staff members were relied upon to respond to complaints of sexual abuse of residents. The culture among some mid-level staff members prevented reports of sexual abuse of residents being passed on to senior management.

## 4.7 Role of the Superintendent and Deputy Superintendent

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The Superintendents of Turana and Winlaton and the Manager of Baltara were responsible for the day-to-day running of the institutions. Mr Green, Dr Owen, Dr Slack and Ms Minister gave evidence about their roles in receiving and responding to allegations of sexual abuse of residents in the institutions.

### The Superintendent at Turana

Mr Green said that, although he did not receive any reports of child sexual abuse perpetrated by an officer while he was the Superintendent at Turana,<sup>411</sup> he was informed through incident reports prepared by Senior Youth Officers and Chief Youth Officers of sexual abuse of residents by other residents.<sup>412</sup>

Mr Green said that he also received complaints of abuse directly from residents during his movement around the institution.<sup>413</sup> He said that he attempted to interact with the residents by visiting each section regularly and holding assemblies but that it was rare for residents to raise ‘major tensions or section problems’ in an open environment with other residents around.<sup>414</sup>

Mr Green gave evidence that, when a complaint of sexual abuse of a resident was received, he relied on Senior Youth Officers and Chief Youth Officers to respond by investigating and preparing an incident report.<sup>415</sup>

### The Superintendent and Deputy Superintendent at Winlaton

Dr Owen, Dr Slack and Ms Minister gave evidence that at Winlaton they attempted to build rapport with staff members and residents by moving around the institution, visiting different sections, eating lunch with residents and Youth Officers and reading the reports from staff daily.<sup>416</sup>

Dr Slack gave evidence that she was aware of the possibility of residents sexually abusing each other<sup>417</sup> and of possible sexual abuse by staff.<sup>418</sup> She said that she never received any formal reports of sexual abuse of a resident by another resident or a staff member during her time as Superintendent.<sup>419</sup> The only incident of sexual abuse that she was aware of concerned a resident who had been raped by her father.<sup>420</sup> Dr Slack accepted Ms Minister’s estimation that hundreds of Winlaton residents had been victims of intra-familial sexual abuse but said that she was shocked by it.<sup>421</sup>

Dr Slack said that she was devastated by the evidence of the survivor witnesses.<sup>422</sup> She acknowledged that every resident had the right to expect her protection as Superintendent and apologised to the victims of sexual abuse.<sup>423</sup>

Dr Slack said that she would have expected Ms Minister, as her Deputy Superintendent, to draw any incidents of sexual abuse of residents to her attention.<sup>424</sup> She accepted that there was no policy

or procedure that would ensure that she received that information.<sup>425</sup> She described the policies, communication and management procedures that she implemented as being ‘inadequate’.<sup>426</sup>

Counsel for Ms Minister submitted that Dr Slack’s evidence that she was only aware of one victim of intra-familial sexual abuse should not be accepted.<sup>427</sup> In oral evidence, Dr Slack said that it did not ‘dawn’ on her that there was a very real possibility that a significant proportion of residents had been sexually abused.<sup>428</sup> Counsel for Ms Minister submitted that this evidence was inconsistent with other evidence before the Royal Commission, including:

- the vulnerability of Winlaton residents
- the referral of some residents to the Children’s Court Clinic for psychiatric assessment
- the development of policies and procedures on sexual abuse at Winlaton
- documentary records of intra-familial sexual abuse
- Dr Slack’s practice of interacting regularly with residents socially and to provide counselling.<sup>429</sup>

Counsel for Ms Minister submitted that Dr Slack was seeking to minimise her responsibility as Superintendent and that ‘at best [her] evidence reveals ... wilful blindness’.<sup>430</sup>

In reply, counsel for Dr Slack submitted it was not put to Dr Slack whether she sought to minimise or elude her responsibility, whether she was ‘wilfully blind’ or whether she was lying about her awareness of intra-familial abuse. Accordingly, counsel for Dr Slack submitted that it was not open to the Royal Commission to draw any adverse inference.<sup>431</sup>

We accept Ms Minister’s points as to the likelihood of wider knowledge of sexual abuse at Winlaton, but there was insufficient evidence at the public hearing that Dr Slack received more than one report of sexual abuse of a resident when she was Superintendent at Winlaton.

We are satisfied that the internal communication, management and reporting procedures in place at Winlaton were not effective in ensuring that the Superintendent was aware of reports of sexual abuse of residents. Based on the evidence before the Royal Commission, we are also satisfied that, during the period that Dr Slack was Superintendent of Winlaton (from the late 1970s to 1991), she did not ensure that there was adequate staff supervision, management and oversight to protect residents from sexual abuse.



## 4.8 Communication of reports of child sexual abuse to external authorities

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### Reporting to the Department

At Turana there was no routine system or procedure for making reports (except annual reports) to the Department. Mr Green stated that, when necessary, verbal and written reports could be made to the Department.<sup>432</sup> He said that there were only a few occasions when he reported specific incidents to the Department (including matters of serious physical assault involving staff or inmates), but he could not recall whether this was put to the Department on notice or if he sought any assistance.<sup>433</sup>

Mr Green said that the Director and Deputy Director of the Department regularly visited Turana to discuss budget, building and facilities as well as problems with residents.<sup>434</sup> He said that, to seek advice, he discussed aggressive behaviour by residents and absconding and kept the Director informed, but it was unclear whether these discussions involved incidents of sexual abuse of residents.<sup>435</sup>

Mr Cadd did not recall seeing any representatives of the Department interact with any of the residents at Turana. He could also not recall being involved in any meetings with the Department about the welfare of residents in his assigned section.<sup>436</sup>

Mr Holland told the Royal Commission that at Baltara there was no opportunity for YACCOs to directly contact the Department to raise incidents of sexual abuse of residents. Any contact with the Department had to be channelled through the Baltara executive.<sup>437</sup> If a staff member ignored this procedure, they risked losing their job.<sup>438</sup> Mr Holland gave evidence that some YACCOs at Baltara made verbal and written complaints to the Department about residents and those complaints appeared to have been forgotten,<sup>439</sup> but YACCOs got into trouble for contacting the Department directly in this way.<sup>440</sup>

We are satisfied that the Department provided little or no oversight of Turana, Winlaton or Baltara and that the responsibility for day-to-day operations, including responding to complaints of sexual abuse of residents, was delegated to senior staff members.

We are also satisfied that, before the 1980s, there were no formal policies or procedures in place at Turana, Baltara or Winlaton for reporting complaints of sexual abuse of residents to the Director of the Department.

## Reporting to the Victoria Police

Mr Green said that referral to the police was contemplated as a strategy for dealing with instances of abuse among residents at Turana, but he could not recall whether such a referral was ever made.<sup>441</sup>

Mr Cadd stated that at Turana the Principal Youth Officer and Superintendent were responsible for deciding whether an incident should be reported to the police.<sup>442</sup> Mr Holland gave evidence that at Baltara, similarly, it was a matter for the executive team to contact the police once an incident report had been completed.<sup>443</sup>

At Winlaton, policies contemplated criminal proceedings for 'major grievances' but not for 'serious incidents'. Before 1987 'serious incidents' included sexual assault.<sup>444</sup> When Dr Slack was questioned about this omission, she said that 'there was no information coming to [her] about sexual assault'.<sup>445</sup>

In addition, the 1980 Winlaton Manual provides:<sup>446</sup>

Normally only the Superintendent (or his delegate) can ask police to enter Winlaton ... Police must never be asked to enter the institution grounds for any reason except that of intercepting intruders.

The 1987 Revised Winlaton Manual provides:<sup>447</sup>

Staff should avoid calling the police, but when they must, the night Senior or ranking officer, should do the calling or, if that is impossible, must be immediately informed of the situation.

Given that:

- mid-level staff were relied upon to respond to complaints of sexual abuse of residents
- some mid-level staff prevented reports of sexual abuse being escalated to senior management,

it was problematic that reports to the Victoria Police were left to senior management. As a result of this procedure for reporting, we consider it highly likely that incidents of sexual abuse of residents were ultimately not reported to the Victoria Police.

## 4.9 ‘Aversion therapy’ and the response to Mr Robert Cummings’ disclosures of sexual abuse

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### Disclosures by Mr Cummings

Mr Cummings gave evidence that when he disclosed to an officer at Turana that he had been sexually abused by another resident, the officer responded, ‘It’s only happening because of your homosexuality ... This is your fault. You need to be cured’.<sup>448</sup>

Mr Cummings said that two officers then physically restrained and ‘frog marched’ him to a doctor at the Royal Park Hospital in Melbourne.<sup>449</sup> He said that the officers threatened to transfer him to Poplar House if he did not behave.<sup>450</sup> Mr Cummings said that at the hospital the doctor told him, ‘You’re here because you’re homosexual and we’re going to cure that with electric shock treatment’.<sup>451</sup>

The response of staff to Mr Cummings’ disclosures of sexual abuse in 1971 was to conclude that he was a homosexual and to refer him to treatment to ‘cure’ him of his homosexuality.

### Administration of aversion therapy treatment to Mr Cummings

The Royal Commission heard that Mr Thomas Verberne, a psychologist at the Parkville Psychiatric Unit in Melbourne, administered ‘aversion therapy’ treatment to Mr Cummings.<sup>452</sup>

Mr Cummings said that he had about 12 sessions of aversion therapy over the course of two months.<sup>453</sup>

Mr Cummings said that at each session he sat on a chair with electrode wires attached to his ankle.<sup>454</sup> A screen was placed in front of the chair and a slide show was played showing pictures of half-naked women and naked men. He said that, when a picture of a naked man appeared on the screen, he was given an electric shock. He described this as ‘a really massive jolt of sharp pain’.<sup>455</sup>

### Response to further disclosures by Mr Cummings

Mr Cummings said that, when the other residents found out that he was receiving ‘treatment’, they labelled him the ‘bum boy’<sup>456</sup> and sexually abused him.<sup>457</sup>

Mr Cummings gave evidence that during the ‘treatment’ the doctor gave him a sheet on which he had to record whether he had engaged in sexual activities with other boys.<sup>458</sup> Mr Cummings said he disclosed this abuse on the sheet and told the doctor about the abuse. He said that, in response, the doctor said, ‘well, we will need to up your dosage of electricity’.<sup>459</sup> Mr Cummings said that from that point on he decided not to disclose any abuse, as he felt he was being punished and not believed.<sup>460</sup>

We accept that this response discouraged Mr Cummings from making further disclosures of sexual abuse. We are satisfied that this caused him considerable trauma and facilitated further abuse.

### Appropriateness of administering aversion therapy to Mr Cummings

Mr Cummings disputed contemporaneous file notes which state that he initially asked for a referral and was prepared to continue the ‘treatment’.<sup>461</sup> He said that he never agreed or gave his consent to receiving aversion therapy<sup>462</sup> and felt that he had no choice about whether to go.<sup>463</sup>

Mr Verberne said that, because Mr Cummings was referred to the Parkville Psychiatric Unit by Dr DJ Hibbs, the psychiatrist at Turana, he had assumed that the appropriate legal approvals had been given.<sup>464</sup>

Counsel for Mr Verberne submitted that it was appropriate for Mr Verberne to assume that there had been proper consultation between Mr Cummings and his treating psychiatrist and that approvals had been obtained.<sup>465</sup>

In response, counsel for Mr Cummings submitted that this position does not take into account Mr Verberne’s duties and obligations as a medical practitioner administering aversion therapy to Mr Cummings. Counsel for Mr Cummings submitted that, for a proper assessment of whether the ‘treatment’ was appropriate, an inquiry into the possibility of sexual abuse should have been made. It was also submitted that Mr Verberne had ongoing obligations to ensure that consent was informed and ‘treatment’ was appropriate.<sup>466</sup>

We accept the submissions of counsel for Mr Cummings. Mr Verberne gave evidence that he did not know or suspect that any child at Turana had been sexually abused.<sup>467</sup> He said that he had never asked whether anyone he was treating had been sexually abused<sup>468</sup> and it was not his practice to ask.<sup>469</sup> Mr Verberne said that in hindsight this would have been relevant in a clinical situation.<sup>470</sup>

Mr Verberne accepted that a child who has been sexually abused is often very powerless and may submit to the demands of powerful adults.<sup>471</sup>

### Conclusions

We are satisfied that, even putting to one side the appropriateness of aversion therapy to ‘treat’ homosexuality, in administering aversion therapy to Mr Cummings Mr Verberne did not exercise an appropriate level of professional scrutiny in that he did not:

- make any proper independent inquiry as to the appropriateness of the ‘therapy’ for Mr Cummings
- adequately consider the possibility that Mr Cummings could have been the victim of sexual abuse rather than engaging in consensual sexual behaviour

- adequately consider Mr Cummings' vulnerability as a ward of the Department
- adequately consider how these circumstances could affect whether Mr Cummings' submission to 'treatment' was truly voluntary.

## 4.10 Triad therapy at Winlaton

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BHE, BDF and Katherine X gave evidence that they participated in a guided group program called 'triad therapy' while at Winlaton.<sup>472</sup> Triad therapy was developed and introduced to Winlaton by Dr Slack.<sup>473</sup>

Triad therapy was the primary setting in which residents at Winlaton could raise any problems they had. It was compulsory and occurred five days per week.<sup>474</sup>

The 1980 Winlaton Manual states:<sup>475</sup>

[Triad therapy] is based upon the theory that rehabilitation is produced in three-role social situations, called triads – (a) the person with the problem now; (b) the person who used to have the problem but now does not; (c) the people who have never had the problem or who had it so long ago that it doesn't matter – teachers, staff, volunteers, parents, friends, etc., who guide the get-together.

Different forms of triad therapy were used at Winlaton, including group sessions involving about 15 residents and 'mini-triads' of just the three people performing each role.<sup>476</sup>

Triad therapy was premised on 'the person with the problem now' acknowledging and accepting responsibility for their problems.<sup>477</sup> Dr Slack said that 'taking responsibility meant understanding what it was that started you into that path which led to many persons' self-destruction'.<sup>478</sup>

The Royal Commission heard evidence from former residents that triad therapy '[assumed] everyone had some big problem'<sup>479</sup> and made them feel 'at fault for what was happening',<sup>480</sup> and that 'the bottom line was that, whatever had happened, was your fault'.<sup>481</sup>

Dr Slack told the Royal Commission that she did not expect residents to disclose or discuss sexual abuse in triad therapy.<sup>482</sup> She said that she did not instruct staff not to discuss sexual problems in triad therapy and that residents could choose whether or not to raise any problems they had.<sup>483</sup>

BHE gave evidence that triad therapy was not an environment where she would have felt comfortable raising the sexual abuse that she experienced.<sup>484</sup>

While it is not clear from the evidence before the Royal Commission whether sexual abuse was ever disclosed or discussed in triad therapy,<sup>485</sup> the Royal Commission heard that many Winlaton residents suffered sexual abuse.<sup>486</sup> Therefore, we consider it possible that residents of Winlaton raised sexual abuse as a problem for discussion in triad therapy.

Dr Slack accepted that it was problematic to introduce triad therapy in Winlaton where staff, including her in her capacity as Superintendent, did not understand the depth of the trauma that some residents had undergone.<sup>487</sup>

As the primary setting for Winlaton residents to raise any problems they were experiencing, triad therapy was an inappropriate forum to receive and respond to any reports of sexual abuse, as it:

- was not directed to, or suitable for, discussions about sexual abuse of residents
- was conducted in a group environment by people not trained in how to respond to those issues
- required the child participant to take responsibility or accept blame for any problems they raised. This would be an entirely inappropriate response to a report of sexual abuse by a child complainant.

## 4.11 Absconding

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### The experiences of residents who absconded

Mr Latham told the Royal Commission that he absconded from Turana twice after he was repeatedly raped by Mr Wilkie and Mr Horne. He said that the first time he ran away he was picked up by police and returned to Turana. The police did not ask him why he had absconded.<sup>488</sup>

Mr Latham said that the second time he ran away he was again picked up by police. However, on this occasion, he was interviewed by a detective. The detective told him that he had ‘better things to do than rounding up absconders from Turana’. Mr Latham responded by telling the detective, ‘Well if you stop the mongrels Wilkie and Horne from raping us inside, we wouldn’t have to abscond’.<sup>489</sup>

Mr Latham said that, in response, the detective hit him on the side of the face with a Bakelite phone. Mr Latham hit the detective back. He was then handcuffed to his chair and told that he would be charged with assault. No investigation of his report occurred and Mr Latham was returned to Turana.<sup>490</sup>

Mr Marijancevic said that he absconded from Turana on many occasions because he was scared of being subjected to further sexual abuse or punishment for reporting sexual abuse.<sup>491</sup> On one occasion, he was picked up by police and asked why he was running away. He responded ‘because they hurt me’. He said that the police officer ‘bashed’ him and returned him to Turana.<sup>492</sup>

BDD said that he absconded from Turana twice to escape sexual abuse by other residents.<sup>493</sup>

BDC and BHE each gave evidence that they ran away from Winlaton many times because they were fearful of other residents and staff<sup>494</sup> or because of the abuse.<sup>495</sup> BDC said that each time she escaped she was picked up by police, charged and returned to the care of the Department. She said that the police never asked her why she absconded.<sup>496</sup>

We accept that some residents absconded from Turana and Winlaton as a result of being sexually abused in the institution or to avoid further sexual abuse in the institution.

### Institutional policies and procedures for residents who abscond

The Turana Manual, 1980 Winlaton Manual and 1987 Revised Winlaton Manual contain largely similar policies about absconding.

The manuals state that the responsible Youth Officer must notify senior staff (for example, the Admitting Officer or Night Senior Officer) if a resident absconds. The Youth Officer must also complete an 'absconding report', which is passed to senior staff (including the Superintendent) and placed on the resident's file.<sup>497</sup> The senior staff must then notify the closest police station.<sup>498</sup>

Mr Cadd gave evidence that, in practice, these policies were not always followed at Turana. He said that both the Chief Youth Officer and the Principal Youth Officer could decide not to report absconding up the chain of command.<sup>499</sup>

Each manual also briefly considers the reasons for absconding. The Turana Manual and 1980 Winlaton Manual state:<sup>500</sup>

[Residents] are unstable for many reasons and as pressure develops in them, or their section, or in their relationships, they resort to absconding. Each officer is expected to show some insight into these problems, and through this, to help reduce absconding.

The Winlaton manuals also provide that, when a resident is returned after she has absconded, a Senior Youth Officer must interview her<sup>501</sup> and complete a prescribed 'Returned Absconder Form', which includes a space to record 'why it took place'.<sup>502</sup>

None of the manuals provided to the Royal Commission refer to child sexual abuse as a possible reason for absconding. We are satisfied that staff at Turana and Winlaton did not recognise that some residents absconded because they were being sexually abused in the institution. Staff members were not given any guidance that some residents absconded because they were being sexually abused in the institution. We are also satisfied that staff were not trained to deal with residents who had absconded because they were being sexually abused in the institution.

### Victoria Police policies and procedures for residents who abscond

The Victoria Police also had policies for dealing with children who had absconded from youth training and reception centres. These policies set out when a child could be apprehended, charged and prosecuted.<sup>503</sup> For example, during the 1980s, residents who had escaped from youth training and reception centres could be apprehended and charged, but police would not commence proceedings against a ward of the Department without first consulting the Department.<sup>504</sup>

The policies of the Victoria Police did not include any procedure for inquiring into the reasons that a resident had absconded. Assistant Commissioner Fontana told the Royal Commission that police would have had general conversations with residents, but some residents would not tell them why they absconded. He accepted that there may have been an attitude to children in youth training and reception centres at the time which meant that police did not inquire into the reasons that residents abscond.<sup>505</sup>

Mr Cadd told the Royal Commission that it was generally transit police who returned residents to Turana after they had absconded. There was limited interaction between police and admitting staff, and Mr Cadd could not recall ever being told that a resident had absconded because of abuse.<sup>506</sup>

Victoria Police policies and procedures did not contemplate that residents might abscond because they were being sexually abused in the institutions. Members of the Victoria Police were not required to inquire into or investigate the reasons that residents had absconded. We are satisfied that the Victoria Police were not prohibited from making such inquiries or investigations and could have done so if they wished.

Assistant Commissioner Fontana told the Royal Commission that he was not sure whether, today, police would routinely ask why residents had absconded.<sup>507</sup> Currently, Victoria Police policies and procedures contain no formal requirement that members inquire into or investigate why a resident has absconded from a youth justice facility.

## 4.12 Response of the Victoria Police to complaints of child sexual abuse

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As set out above, the Victoria Police played an important role for children placed in youth training and reception centres, particularly when a resident absconded from a youth training or reception centre. The Victoria Police also played, and continue to play, an important role in responding to sexual abuse of residents.

### Historical policies and procedures of the Victoria Police

There was no overarching protocol between the Victoria Police and the Department, or between the Victoria Police and youth training and reception centres, for receiving and responding to reports of sexual abuse of residents. Rather, Assistant Commissioner Fontana said, local police stations and any institutions that fell within their area had arrangements between them.<sup>508</sup>

The Victoria Police could not locate any documents recording these arrangements,<sup>509</sup> but Assistant Commissioner Fontana said that it was likely that local police stations developed their own standard operating procedures for responding to particular incidents in their specific areas.<sup>510</sup>



## Historical attitude of the Victoria Police

Assistant Commissioner Fontana stated that, historically, there was ‘a lot of disbelief’ within the Victoria Police about child sexual abuse – even more so when the complainant was a resident of a youth training or reception centre.<sup>511</sup> There was a view among some members of the Victoria Police that residents were ‘juvenile delinquents’ or ‘troublemakers’ who were not believable and would not make credible or reliable witnesses.<sup>512</sup>

Assistant Commissioner Fontana accepted that, during the 1960s, 1970s and 1980s, some police officers thought it was appropriate or necessary to use force and physical discipline with children admitted or committed to state-run youth training and reception centres.<sup>513</sup>

Assistant Commissioner Fontana said that, historically, police had ‘very little understanding of the complexities of sexual offending, sexual offenders and, in particular, victims and their experiences’. He said that police ‘did not fully understand’ how a victim of sexual abuse might present, why they might delay reporting to police or others, and why they may suffer ‘broken recollections’.<sup>514</sup>

Assistant Commissioner Fontana said that this position did not change much until 2004, when the Victorian Law Reform Commission prepared a report entitled *Sexual offences: Law and procedure final report* (2004 VLRC Report).<sup>515</sup> Assistant Commissioner Fontana told the Royal Commission that the 2004 VLRC Report was the catalyst for major structural, practical and cultural reforms. He said that this report found that ‘the police response to sexual assault was undermined by a culture of disbelief, a deficit in the skills and knowledge of investigators and a lack of transparency in the process’.<sup>516</sup>

We accept that before 2004 members of the Victoria Police were not adequately trained to recognise, understand or respond to child sexual abuse. We are satisfied that many responses to reports of child sexual abuse were entirely unsatisfactory.

## Current practice of the Victoria Police

Assistant Commissioner Fontana said that in recent years efforts have been made to improve communication between the Victoria Police and youth justice centres to encourage reporting and to deal collaboratively with some of the issues concerning young people.<sup>517</sup>

Assistant Commissioner Fontana referred to the ‘Protecting Children – Protocol between Child Protection and Victoria Police, 2012’ (the Protocol), saying:<sup>518</sup>

[The Protocol] provides guidance to both [the Department] and Victoria Police to ensure that an effective response to child abuse and neglect is provided by both services for children who have suffered, or are likely to suffer, significant harm due to physical, sexual, emotional or psychological abuse and/or neglect. The Protocol articulates the statutory and non-statutory responsibilities of both [the Department] and Victoria Police and how they

will interact with each other. The statutory responsibilities of Victoria Police in relation to child abuse are outlined in the Victorian Children, *Youth and Families Act 2005* which provides that police are protective interveners and mandatory reporters.

Pursuant to the Protocol, the Department must contact police to report sexual assault within a youth justice centre.<sup>519</sup> Where both the victim and the offender are residents of the youth justice centre, a joint investigation is undertaken pursuant to the Protocol.<sup>520</sup> Assistant Commissioner Fontana said that the youth justice centre has a responsibility to ensure the safety of the suspect, the victim and other residents.<sup>521</sup>

In addition, following the 2004 VLRC Report, Sexual Offence and Child Abuse Investigations Teams (SOCITs) were established to investigate sexual offences and child abuse.<sup>522</sup> Assistant Commissioner Fontana said that members of SOCITs undergo a four-week training course to address the complexities of investigating sexual offences.<sup>523</sup> A significant component of the course focuses on responding to, and investigating, child sexual abuse. It covers child development, interviewing children, working with child protection, and sexual exploitation of children in residential care.<sup>524</sup>

## 5 The experience of Katherine X

The public hearing examined the experience of Katherine X at Winlaton and the response of Winlaton and Department staff to her reports of sexual abuse.

Katherine X was placed at Winlaton for about five months between March and August 1979, when she was 14 years old.<sup>525</sup>

Before she was placed at Winlaton, Katherine X was repeatedly raped by her father.<sup>526</sup> She disclosed this sexual abuse to social workers before being removed from parental care.<sup>527</sup> She also disclosed this sexual abuse to youth workers and other Department staff at Winlaton.<sup>528</sup>

In August 1979, Katherine X was transferred from Winlaton to Hillview Hostel (Hillview) – a non-government residential institution.<sup>529</sup> In late 1980, Katherine X moved back into her parents' house. She told the Royal Commission that, when she returned home, her father began to rape her every day and threatened her with violence if she refused.<sup>530</sup>

Katherine X told the Royal Commission that the emotional, physical and sexual abuse continued for the next 24 years, until 2005.<sup>531</sup> She gave birth to four children fathered by her father and suffered two miscarriages. Her youngest child, a daughter, was born premature and died two and a half months after birth due to health complications.<sup>532</sup>

In February 2010, Katherine X's father was sentenced to a term of imprisonment of 22 years and five months, with a non-parole period of 18 years, for the offences he committed against her.<sup>533</sup>

During the public hearing, the following events and issues were examined in detail:

- the approach and level of understanding of Winlaton and Department staff to incest
- the lack of communication between Winlaton or Department staff and the Victoria Police
- Katherine X's father being permitted to visit her at Winlaton
- Katherine X being released on day and weekend leave from Winlaton back to the family home
- Katherine X being transferred to Hillview, which gave her father unrestricted access to her
- the administration of Depo Provera to Katherine X and other residents
- a letter written by staff to Katherine X's father just after her transfer to Hillview informing him of their knowledge of the 'sexual relationship' between Katherine X and her father.

The following people involved in Katherine X's care in 1979 gave evidence at the public hearing:

- Mr Fitzgerald – a regional welfare officer and caseworker
- Ms Jennifer Mitchell (nee Lines) – a social worker within the Liaison and Referral Unit at Winlaton, which liaised between regional caseworkers and Winlaton staff to provide support for case management<sup>534</sup>
- Dr Michael Groome, the senior psychiatric nurse at the Children's Court Clinic, which provided psychiatric and psychological assessment and treatment to the residents of Winlaton and other youth training centres<sup>535</sup>

- Ms Minister, a Deputy Superintendent of Winlaton from 1975 to 1992
- Dr Slack, a Deputy Superintendent from 1976 to 1978 and Superintendent from 1979 to 1991.

At the public hearing, Dr Groome said that he had no recollection of Katherine X as a result of his current personal health issues.<sup>536</sup> The evidence he gave at the public hearing was based on the documents produced to the Royal Commission and provided to him.<sup>537</sup> Mr Fitzgerald, Ms Minister and Dr Slack also had no independent recollection of Katherine X.<sup>538</sup> Ms Lines told the Royal Commission that she remembered Katherine X but could not remember specific events.<sup>539</sup>

## 5.1 Katherine X's disclosures of abuse in 1979

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### Katherine X's sexual abuse by her father

In 1971, when Katherine X was seven years old, she was admitted to the care of the Department because she was deemed to have 'no visible means of support'.<sup>540</sup> She was placed in a non-government residential institution for about four years.<sup>541</sup>

In 1976, when Katherine X was 12 years old, she was returned to her mother's care but remained a ward of the Department.<sup>542</sup> At that time, Katherine X's father was involuntarily detained in a psychiatric unit.<sup>543</sup> In 1977, her father returned to live with the family. Katherine X said that the sexual abuse began soon afterwards.<sup>544</sup>

Katherine X said that over time the abuse became more frequent and more aggressive and that her father continuously raped, physically abused and threatened her, at times daily.<sup>545</sup>

In early 1979, when Katherine X was 14, she began running away and self-harming.<sup>546</sup> She spent time in a couple of residential institutions. Documents produced to the Royal Commission show that before she was placed at Winlaton she told Ms Carolyn Pearl, a social worker from the Department, and Mr Fitzgerald, her Department case worker, that her father was sexually abusing her.<sup>547</sup>

### Disclosure to Victoria Police in 1979

In March 1979, after running away from another institution, Katherine X was picked up by police and taken to Winlaton.<sup>548</sup> Katherine X said that she told police that she was running away because her father was raping her. Her evidence was that she was told that she could not make a formal statement unless she was with an adult.<sup>549</sup>

Assistant Commissioner Fontana gave evidence that he was disappointed that the Victoria Police took no action at that time.<sup>550</sup> He said that in 1979 the Victoria Police did have the ability to provide adult support to a victim making a statement. He said that specially trained policewomen were available to take statements and deal with young people.<sup>551</sup>

A standing order in place in the late 1970s refers to a Sexual Offences Squad of detectives trained in taking initial complaints from children who had reported being the victim of a serious sexual offence. The standing order provides that, if a member of the squad is not available, a suitably qualified policewoman should perform these duties.<sup>552</sup>

We are satisfied that in 1979 the Victoria Police did not comply with the applicable procedures and failed to properly investigate the allegation of child sexual abuse that Katherine X made. This failure allowed the sexual abuse of Katherine X to continue.

### Disclosures at Winlaton

Katherine X said that while she was at Winlaton she told a number of her assigned youth workers that her father had raped her. She said that some of the youth workers believed her and were really supportive, but others did not believe her or made her feel as though she was to blame.<sup>553</sup>

Katherine X stated that at Winlaton she participated in triad therapy.<sup>554</sup> She was not sure whether she had disclosed during triad therapy that her father had raped her, but she recalls that triad therapy did not assist her to protect herself from her father.<sup>555</sup> She said that triad therapy made her feel as if she was to blame for what was happening.<sup>556</sup>

The documentary evidence before the Royal Commission shows that Katherine X disclosed sexual abuse to staff at Winlaton, including Ms Lines, who was a Department employee attached to Winlaton.<sup>557</sup>

Katherine X also made disclosures on 'Personal Report Sheets'.<sup>558</sup> Personal Report Sheets were filled out by residents for discussion at classification meetings.<sup>559</sup> Katherine X said that, once the forms were completed, she handed them to her youth worker.<sup>560</sup>

Five Personal Report Sheets were produced to the Royal Commission. They are dated 18 April, 8 May, 22 May, 5 June and 17 July 1979.<sup>561</sup> On each Personal Report Sheet, Katherine X disclosed sexual abuse or a 'serious problem' with her father.<sup>562</sup> In the Personal Report Sheet dated 18 April 1979, Katherine X wrote:<sup>563</sup>

My most serious problem is the relationship with my father. As my father has an emotional hold over me. He has force[d] me to have sex with him.

In April 1979, Katherine X was referred to, and began meeting with, Dr Groome, the senior psychiatric nurse from the Children's Court Clinic.<sup>564</sup> Dr Groome regularly met with Katherine X while she was at Winlaton to provide counselling.<sup>565</sup> He also met with Katherine X's mother and grandparents to discuss her disclosures of sexual abuse.<sup>566</sup>

Throughout the period Katherine X was at Winlaton, she continued to disclose that her father had sexually abused her and that she was afraid of him.<sup>567</sup>

As mentioned above, during the public hearing Dr Groome told the Royal Commission that he has ‘memory issues’ as a result of suffering seizures in 2012.<sup>568</sup> He said that he has no recollection of Katherine X.<sup>569</sup> He gave evidence based on the documents produced to the Royal Commission and provided to him.<sup>570</sup> The evidence Dr Groome gave during the public hearing as to the response he took to Katherine X’s disclosures of sexual abuse is set out below.

## 5.2 No report from Winlaton or Department staff to Victoria Police

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As set out in section 4.2 above, in 1979, when Katherine X was a resident at Winlaton, there were no policies in place about how or when allegations or incidents of sexual abuse of residents should be reported to police.<sup>571</sup>

During the period that Katherine X was at Winlaton, Mr Fitzgerald, Ms Lines, Dr Groome and Ms Minister were aware that Katherine X had disclosed being sexually abused by her father.<sup>572</sup>

Despite this awareness, Mr Fitzgerald, Ms Lines, Dr Groome and Ms Minister did not report Katherine X’s disclosures of sexual abuse to the Victoria Police. It was not contested that Katherine X’s disclosures should have been reported to the Victoria Police.<sup>573</sup>

Ms Minister told the Royal Commission that in 1979 she did not consider that she was obliged to report the matter to the Victoria Police because incest was generally dealt with as a matter of family dysfunction.<sup>574</sup>

Mr Fitzgerald, Ms Lines and Dr Groome gave evidence that they did not report the matter to the Victoria Police because they were inexperienced and confused about the decision-making process.

### Approach of Winlaton and Department staff to incest

Historically, the State of Victoria treated the crime of incest as a serious crime that attracted a term of imprisonment for life. The *Crimes Act 1891* (Vic) provided that it was a felony for a father to sexually abuse a girl over the age of 10 known to be his daughter.<sup>575</sup> The Crimes Act underwent a number of amendments, but the crime of incest remained a serious criminal offence that attracted a term of imprisonment.

The *Crimes Act 1958* (Vic) applied at the time that Katherine X was a ward of the Department during the 1970s and early 1980s. At the time, the then section 52 of the Crimes Act made it an offence for a person to take part in an act of sexual penetration with a person of or above the age of 10 and whom he knows to be his child. At the time, the maximum penalty for committing the crime of incest was a term of imprisonment for 20 years.<sup>576</sup> Incest remains a serious crime in Victoria today and attracts a maximum penalty of 25 years imprisonment.<sup>577</sup>

The Royal Commission heard evidence that during the 1970s and early 1980s some staff members at Winlaton viewed incest as a symptom of family dysfunction rather than a criminal offence in which the child was a victim. This was despite the history of legislation in Victoria stating that incest was a serious crime.

Mr Fitzgerald, Ms Lines and Dr Groome gave evidence that in 1979 they viewed allegations of incest as serious and were aware that incest was a crime.<sup>578</sup>

Despite this view, the Royal Commission heard that in the 1970s and 1980s there was an emphasis on therapeutic intervention rather than reporting matters of incest to police.<sup>579</sup> Dr Groome said, '[T] here was [an] attempt to try and work with the family, no matter how ... broken it was'.<sup>580</sup>

In relation to Katherine X, those involved in her care gave evidence that they took on an approach of therapeutic intervention, where incest was viewed as a matter of family dysfunction.<sup>581</sup> Katherine X gave evidence that at times this approach made her feel like the focus was on protecting her father and his feelings<sup>582</sup> and that her cries for help had not been heard.<sup>583</sup>

We are satisfied that the approach of Winlaton and Department staff to incest resulted in some staff not recognising the seriousness of the crime of incest and its impact on victims. Furthermore, this approach failed to protect Katherine X from her father's ongoing crimes against her.

### Inexperience of staff

Mr Fitzgerald said that he was 'very inexperienced and not qualified'.<sup>584</sup> Mr Fitzgerald, Dr Groome and Ms Lines said that before becoming involved with Katherine X they received no training specifically about reporting or responding to sexual abuse of residents.<sup>585</sup>

Mr Fitzgerald and Dr Groome told the Royal Commission that they would have discussed the case of Katherine X with a supervisor or other more experienced colleague because it was so serious.<sup>586</sup>

Dr Groome said that his role was 'autonomous' and that there was 'minimal supervision'.<sup>587</sup> He said that any consultations with a supervisor about a resident were informal and that he did not take notes.<sup>588</sup>

Ms Lines gave evidence that in her position at the Liaison and Referral Unit she was unsure who her supervisor was<sup>589</sup> and that her relationship with staff in head office was more managerial than supervisory.<sup>590</sup>

### Confusion about the decision-making process

Mr Fitzgerald and Ms Lines told the Royal Commission that there was a team of people responsible for making decisions about Katherine X's care in 1979, but staff at Winlaton took the primary role when she was placed there.<sup>591</sup>

Dr Groome stated that in his role he could consult and make recommendations, but he had no power to make decisions about the management of young people under the care of the Department.<sup>592</sup> He said that he attended case meetings<sup>593</sup> and accepted that, as somebody giving expert psychiatric or psychological advice, he had a significant role in the joint decision-making process.<sup>594</sup> He said that his recommendations were not always acted upon, but he accepted that they were given some weight in the decision-making process.<sup>595</sup>

Dr Groome said that he would have thought that something would already have been done about Katherine X's disclosures because they were so widely known within the Department.<sup>596</sup>

Counsel for Ms Lines submitted that other staff members were aware of Katherine X's disclosures and were better placed to report them to the Victoria Police.<sup>597</sup>

Counsel for Mr Fitzgerald submitted that Mr Fitzgerald's failure to report should be considered in light of the lack of clear policies and procedures at the time and the report he made to his supervisor.<sup>598</sup> Counsel for Mr Fitzgerald also submitted that, if a disclosure of sexual abuse were made to Mr Fitzgerald today, the current procedures of the Department would require him to report any disclosures of sexual abuse to the most senior staff member, who is ultimately responsible for reporting the allegation of sexual abuse to the police.<sup>599</sup>

Counsel for the State of Victoria submitted that the current departmental policy, when read as a whole, provides that all staff members who are aware of an allegation of sexual abuse carry the obligation to report the matter to the police.<sup>600</sup> Since 2014, failure to disclose child sexual abuse to a police officer is a criminal offence, although reasonable belief that another person has already disclosed the relevant information to the police is a defence.<sup>601</sup>

However, it should be noted that this policy will only be effective if adequate training and supervision is provided to staff.

We are satisfied that:

- in 1979 at Winlaton there was a lack of policies and procedures for dealing with reports of sexual abuse of residents. This resulted in:
  - lack of clarity about who was ultimately responsible for making key decisions
  - the response to Katherine X's disclosures of sexual abuse falling to inexperienced, junior staff members
  - Katherine X's disclosures of sexual abuse not being reported to the Victoria Police
- there was a lack of training for staff to understand the dynamics of incest and the impact on the child.

The lack of policies and training, and the confusion about who was responsible for the decisions about Katherine X's care, did not excuse or prohibit Mr Fitzgerald, Ms Lines, Dr Groome and Ms Minister from reporting Katherine X's sexual abuse. This lack of policies, procedures, training and



supervision led to a failure to protect Katherine X from ongoing crimes perpetrated by her father, together with a failure to provide Katherine X with the psychological support she required at the time she was in the care of the Department.

## 5.3 Contact between Katherine X and her father

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### Visits to Winlaton by Katherine X's father

Katherine X gave evidence that she remembered her father visiting her at Winlaton on one occasion. She said that she was told about the visit 10 minutes before her father arrived.<sup>602</sup>

Katherine X said that during the visit her father leaned towards her, squeezed her thigh hard and said words to the effect of 'Keep your fucking mouth shut'. She stated that there was a youth worker sitting nearby, but there was no intervention during the visit.<sup>603</sup>

Documentary evidence suggests that Katherine X's father visited her in Winlaton twice – in May and June 1979.<sup>604</sup> File notes made by Dr Groome dated 30 May 1979 record that 'staff were struck by the "sensuousness" of the relationship' between Katherine X and her father.<sup>605</sup> A Progress Report of Winlaton Psychiatric Services dated 14 June 1979 records that Katherine X 'feared [the visit] when she was told of it'.<sup>606</sup>

Katherine X's father should not have been permitted to visit her at Winlaton because the visit exposed Katherine X to a serious risk of further harm.

Katherine X gave evidence about the impact the visit had on her at the time and in the present day. She said:<sup>607</sup>

I felt like a robot that had stopped feeling, and began self-harming again. To this day I still consider the day that my father visited me as one of the greatest betrayals of my life. His visit made me feel like there was no escape from him.

### Katherine X released on day and weekend leave

Katherine X also gave evidence that while she was at Winlaton she was allowed to go home to visit her mother. Katherine X said that, although she could not recall whether her father lived with her mother at the time, during her temporary release from Winlaton her father often visited her.<sup>608</sup>

A Progress Report of the Winlaton Psychiatric Service dated 14 June 1979, completed by Dr Groome, states, '[Katherine X] should have weekend leave if mother requests it'.<sup>609</sup>

Handwritten notes of Dr Groome dated 20 June 1979 record:<sup>610</sup>

Bad weekend – father made sexual advances – which she refused. ...

He had asked her to run away to NSW, she managed to refuse.

### Lack of policies and procedures on permissions for visits and leave

The 1980 Winlaton Manual includes policies on visiting and leave.<sup>611</sup> It is unclear whether this policy or a similar policy applied during Katherine X's residence at Winlaton in 1979.<sup>612</sup>

The policies do not set out when permission for a visit or leave should be granted or refused or what factors should be considered in the decision-making process.

Further, there are no policies about supervision during visits or conducting any form of risk assessment before granting permission for leave.

### Decisions about contact between Katherine X and her father

At the public hearing, the decision to permit Katherine X's father to visit her in Winlaton was examined in some detail.

A memorandum from Ms Minister to Dr Groome dated 13 June 1979 states:<sup>613</sup>

[Katherine X's father] rang me yesterday to ask permission to visit [Katherine X] today (Wed) at 10:30 or 11AM. Permission granted.

Perhaps you would like to arrange to see him then also.

Ms Minister gave evidence that, as the Deputy Superintendent, she chaired weekly case planning meetings.<sup>614</sup> She acknowledged that she was ultimately responsible for decisions about placement, weekend leave, transfers and visits.<sup>615</sup>

Ms Minister accepted that, as a result of her attendance at classification meetings and the referral to Dr Groome at the Children's Court Clinic on 20 April 1979, she was aware of the sexual abuse perpetrated by Katherine X's father.<sup>616</sup>

Ms Minister told the Royal Commission that she made a mistake in granting permission for Katherine X's father to visit her in Winlaton.<sup>617</sup> She accepted that, given the circumstances, for Katherine X to be subjected to such a visit was in itself a form of sexual abuse.<sup>618</sup>

Ms Minister permitted Katherine X's father to visit Katherine X at Winlaton even though she was aware that Katherine X had been sexually abused by her father.

Dr Groome gave evidence that there was a 'general flavour' in the documents that he was discouraging contact with the father.<sup>619</sup> He said that he was 'not necessarily involved in' decisions about Katherine X's contact with her father.<sup>620</sup>

Ms Minister said that Dr Groome would have been consulted about whether Katherine X's father should be permitted to visit Winlaton or whether Katherine X should be released on leave.<sup>621</sup>

Counsel for Ms Minister submitted that Ms Minister's evidence about Dr Groome's probable involvement in the decision-making process should be accepted given the significant difficulties Dr Groome has with his memory.<sup>622</sup>

We are satisfied that Dr Groome was aware that Katherine X had been sexually abused by her father and was in a position to give his advice and opinion on whether to allow Katherine X's father to visit her at Winlaton. Dr Groome failed to help protect Katherine X from further harm.

### Supervision during contact between Katherine X and her father

Ms Minister gave evidence that she would only have granted permission for Katherine X's father to visit because she thought that the visit would be closely supervised.<sup>623</sup>

Similarly, both Ms Minister and Dr Groome gave evidence that permission for leave would only have been granted on the understanding that her parents were separated and that Katherine X would not have contact with her father.<sup>624</sup> Counsel for Ms Minister submitted that staff at Winlaton were of the firm understanding that Katherine X's mother would not allow contact between Katherine X and her father and Ms Minister had to rely on the quality of the information she was provided with.

We do not accept this submission. We are not satisfied on the evidence of Ms Minister and Dr Groome that a risk assessment was conducted or any other process was implemented to ensure that Katherine X would be safe while on leave.<sup>625</sup> There was no evidence of any risk assessment being undertaken before leave was granted. Dr Slack gave evidence that she was unaware of any risk assessment process and accepted that this was a 'major oversight'.<sup>626</sup>

We are satisfied that staff of Winlaton and the Department released Katherine X on weekend and day leave without taking any action to minimise the risk that her father would continue to sexually abuse her. This exposed Katherine X to a serious risk of further harm.

## 5.4 Involvement of Dr Slack

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Dr Slack was the Superintendent of Winlaton when Katherine X was a resident there.<sup>627</sup> She told the Royal Commission that the sexual abuse of Katherine X by her father was never brought to her attention<sup>628</sup> and she was not aware of it.<sup>629</sup>

Dr Slack said that, if she had known, she would have:

- ordered that Katherine X's father not be allowed to visit<sup>630</sup>
- not permitted Katherine X to be released on leave to her mother<sup>631</sup>
- reported the matter to the police.<sup>632</sup>

Dr Slack said that she would have expected her subordinates, including Deputy Superintendent Ms Minister, to inform her about this situation.<sup>633</sup> She accepted that there was no policy or procedure to ensure that she would receive this type of information.<sup>634</sup>

Ms Minister said that she would 'not necessarily' have brought cases like that of Katherine X to the Superintendent's attention because the Superintendent was not normally involved in case planning.<sup>635</sup>

## 5.5 The effect of confusion about decision-making on Katherine X

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Katherine X told the Royal Commission that while she was at Winlaton her feelings about her father were extremely complicated. She said that, although she was scared of him and wanted the rapes to stop, she also wanted to see him and craved his affection.<sup>636</sup>

A number of witnesses gave evidence that it was left to Katherine X to decide whether her disclosures should be reported to the police and whether she should see her father.

Dr Groome said that part of the reason he did not report the disclosures to the police was that he wanted to respect Katherine X's request that no report be made.<sup>637</sup> Ms Lines and Dr Groome said that they were also concerned to preserve their relationship with Katherine X so that they could support her and assist her to separate from her father.<sup>638</sup>

Ms Minister said that she would only have given permission for Katherine X's father to visit if Katherine X had indicated that she wanted to see her father. She accepted that it was a mistake to let Katherine X decide whether to see her father or not.<sup>639</sup> She accepted that the fact that she permitted visits from Katherine X's father sent mixed messages to Katherine X about whether she should have contact with her father.<sup>640</sup>

The lack of policies and procedures at Winlaton in 1979 for dealing with reports of sexual abuse of residents meant that staff did not take clear and decisive action for the care and protection of Katherine X. This contributed to Katherine X's feeling of confusion and helplessness.

## 5.6 Administration of Depo Provera to Katherine X

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Katherine X gave evidence that soon after she arrived at Winlaton staff began giving her regular injections of Depo Provera as a form of contraceptive.<sup>641</sup> A document entitled 'Gynaecological History' records that multiple injections were administered to Katherine X between early April 1979 and January 1980. It also contains a handwritten note: 'claims incest father'.<sup>642</sup>

These injections continued when she was transferred to Hillview in August 1979.<sup>643</sup> A document entitled 'Hillview Review' and dated 4 January 1980 states:<sup>644</sup>

[Katherine X] is due for another depo provera (contraceptive) injection. As she is keen to have another injection, despite no known sexual activity with boys, then continued contact with her father seems a real possibility.

Depo Provera was not approved for general use in Victoria until 1991.<sup>645</sup> A departmental policy entitled 'Guardianship Services Manual', dated 1984, states that it was classified as an 'experimental drug because its effects on the human body have been insufficiently tested and evaluated'.<sup>646</sup>

Medical staff at Winlaton were responsible for the introduction and administration of Depo Provera.<sup>647</sup> When Dr Slack was Superintendent, she repeatedly objected to the administration of Depo Provera, but its use continued.<sup>648</sup>

Dr Slack, Dr Owen and Ms Minister acknowledged that Depo Provera was administered to residents to counter the risk of unwanted pregnancy.<sup>649</sup>

The Guardianship Services Manual provided that, before Depo Provera could be administered, staff must ensure that the resident had read, understood and signed a consent form. Consent also had to be sought from the residents' parents unless the Department had authority, pursuant to the legislation, to override the parents' wishes.<sup>650</sup>

The Royal Commission heard evidence that some former residents were not given a choice.<sup>651</sup> The Royal Commission heard that girls who were wards of the Department were not allowed to go on weekend leave unless they had an injection of Depo Provera.<sup>652</sup>

Ms Minister said that residents did have a choice about what action they took in terms of contraception.<sup>653</sup> She said that there was an extensive consent form that medical staff thoroughly discussed with the resident and that, for residents under 16 years of age, parental permission or the permission of the Director of the Department was obtained.<sup>654</sup> Residents over 16 were capable of signing their own consent form.<sup>655</sup>

An undated consent form for the administration of Depo Provera to Katherine X, signed by Katherine X's mother, was produced to the Royal Commission.<sup>656</sup> This was the only evidence of Katherine X's consent produced to the Royal Commission.

We are satisfied that medical staff of Winlaton administered Depo Provera to residents as a contraceptive when it was unclear whether consent had been properly obtained for administration.

Dr Slack accepted that placing a child thought to be at ongoing risk of sexual abuse by her father on a contraceptive to ensure that she was not getting pregnant, yet to not report that abuse to the police, was a wholly inappropriate institutional response.<sup>657</sup>

Administration of Depo Provera to Katherine X was a wholly inadequate response to her disclosures of sexual abuse because it did not protect her from her father's ongoing crimes against her.

## 5.7 Transfer to Hillview Hostel

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Katherine X gave evidence that in June 1979 staff at Winlaton and the Department decided she should be transferred from Winlaton to Hillview – a non-government youth hostel.<sup>658</sup>

A Hostels Referral Form completed by Mr Fitzgerald and dated 25 June 1979 states the reason for the referral from Winlaton to Hillview: 'It is felt that [Katherine X] still requires the support of a hostel situation because of the existing father/daughter relationship difficulties.'<sup>659</sup>

The form also records Mr Fitzgerald's comments about Katherine X's relationship with her family. It states:<sup>660</sup>

[Katherine X]'s relationship with her father is complexed [sic]. [Katherine X] claims that her father has an emotional hold over her and has taken advantage of her sexually in recent years ...

Mr Fitzgerald accepted that the form does not adequately reflect the risk of harm to Katherine X that her father posed<sup>661</sup> and it should have been better articulated.<sup>662</sup>

Katherine X gave evidence that she was transferred from Winlaton to Hillview on 8 August 1979.<sup>663</sup> She was still under the care of the Department.

Katherine X said that after she was transferred from Winlaton to Hillview her father began raping her again almost immediately.<sup>664</sup>

Staff at Winlaton did not have further involvement in Katherine X's care after she was transferred to Hillview.<sup>665</sup> Ms Lines and Dr Groome gave evidence that, once Katherine X was transferred, her regional worker and the staff at Hillview were responsible for her care.<sup>666</sup>

A Progress Report dated 1 August 1979 records that Dr Groome intended on 'following [Katherine X] up for a period if/when she moves to Hillview'.<sup>667</sup> The Royal Commission was not provided with any documents or any other evidence to suggest that Dr Groome had contact with Katherine X after she was transferred from Winlaton.<sup>668</sup>

The Royal Commission heard that, just before Katherine X was transferred to Hillview, Mr Fitzgerald moved to another office and Ms Brigid Beirne took over as her departmental caseworker.<sup>669</sup>

The Department did not ensure that Katherine X received continuity of service from social and welfare workers. This impeded an effective response to Katherine X's disclosures of sexual abuse.

Ms Minister said that staff from Hillview were made aware of Katherine X's situation by the Hostels Referral Form (extracted above).<sup>670</sup> Other documents completed by Ms Beirne show that staff at Hillview were aware of Katherine X's disclosures of sexual abuse.<sup>671</sup>

We are satisfied that staff of Winlaton and the Department transferred Katherine X from Winlaton to Hillview without ensuring that she would be protected from further sexual abuse by her father.

## 5.8 Letter to Katherine X's father

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The Royal Commission was provided with a letter dated 9 August 1979 and addressed to Katherine X's father. The letter states:<sup>672</sup>

[Katherine X] has asked us to write to you because none of us has seen you for a while and she feels that she would like you to know some of the things that she's been telling us about your relationship. She has shown us your letter and it is obvious that she is very important to you. You both seem to care very much for each other, but [Katherine X] has told us that your relationship has been a sexual one for some time and when she first came to Winlaton she asked us for help in sorting out her feelings about this. While [Katherine X] loves you very much, she is not happy with the relationship as it is, and our feeling is that your caring for each other is not expressed in an appropriate way.

[Katherine X] feels that it is not good for her to be involved with you in the way that she is and, during her time here, she has been trying to sort out her feelings so that she can feel more comfortable about seeing you, but she needs to feel that you are willing to change the relationship also. She asked us to tell you all this as she felt that it was unfair that you did not know while we did. She is very worried that you will feel hurt by this letter but believes that she ought to be honest with you. None of us wants to make you feel bad, but we do want [Katherine X] to feel better about her relationship with you. In telling you that she has told us about your relationship, she is not trying to hurt [you] but rather is trying to deal with the situation in a mature and honest way and this is just one example of the growing up that [Katherine X] has done whilst at Winlaton, and I guess we all hope that you see this letter in the same light.

The names of 'Jennifer Lines' and 'Michael Groome' are typed at the foot of the letter, but the letter is signed only by Ms Lines.

Dr Groome was unable to recall what role, if any, he played in drafting and sending this letter.<sup>673</sup> Counsel for Katherine X submitted that the Royal Commission could not be satisfied that Dr Groome did not sign the copy of the letter sent to Katherine X's father, as the copy produced to the Royal Commission was retrieved from the Winlaton file.<sup>674</sup>

Ms Lines accepted that the decision to send the letter was a joint decision made by staff at an earlier meeting.<sup>675</sup> Ms Minister said that she thinks that she would have been involved in the decision to send the letter, but she would not have read the letter before it was sent.<sup>676</sup>

Katherine X gave evidence that, contrary to what the letter stated, she had not asked for the letter to be sent.<sup>677</sup> Ms Lines stated that, although she cannot now recall Katherine X asking her to write the letter, she would not have written it if she had not believed that she had permission.<sup>678</sup> She accepted that it was not Katherine X's idea to send the letter<sup>679</sup> and that it was possible that Katherine X felt pressure to give permission for the letter to be sent.<sup>680</sup>

Ms Lines and Dr Groome gave evidence that the letter could have been worded 'better' or 'differently'.<sup>681</sup> Both gave evidence that the letter was written in a conciliatory way to prevent aggravating Katherine X's father<sup>682</sup> and to reflect Katherine X's 'ambivalence' towards him.<sup>683</sup>

On the evidence before the Royal Commission and on the documents available, we are unable to determine whether Katherine X asked for the letter to be sent or who was involved in the decision to send the letter.<sup>684</sup> In any event, we are satisfied that the letter was an inappropriate response to Katherine X's disclosures of sexual abuse because:

- it alerted Katherine X's father to the fact that she had disclosed the abuse and thereby increased the risk of further harm to her
- it was sent just after Katherine X had been transferred to a less secure institution and no safeguards had been put in place to prevent her father from having further access to her
- it indicated a tolerant attitude and completely downplayed to Katherine X's father the seriousness of his criminal conduct.

## 5.9 Report to the Victoria Police in 2002

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Katherine X told the Royal Commission that after her wardship was discharged in 1981<sup>685</sup> she did not report the sexual abuse for many years because she did not think she would be believed.<sup>686</sup>

Katherine X said that in 2002 she disclosed the sexual abuse to a counsellor at the Centre Against Sexual Assault. She gave evidence that the counsellor reported the matter to the police SOCIT unit. Within a short period of time, a policewoman and a child protection officer from the Department came to her house to investigate the report.<sup>687</sup>



Katherine X said that she found the policewoman judgmental and untrustworthy.<sup>688</sup> She gave evidence that she felt like she was going to be charged for being a victim.<sup>689</sup> As a result, she was afraid that her children would be removed from her and ultimately she denied the abuse. Katherine X said that the investigation ended after about three months.<sup>690</sup>

Assistant Commissioner Fontana said that he found the response of the Victoria Police to Katherine X's reports in 2002 'disappointing'<sup>691</sup> and accepted that it re-traumatised Katherine X.<sup>692</sup>

Assistant Commissioner Fontana said that before the 2004 VLRC Report there were occasions when the Victoria Police did not believe reports of sexual abuse and would 'grill' victims of these serious crimes.<sup>693</sup> He gave evidence that the 2004 VLRC Report resulted in a significant change in the way that the Victoria Police approach investigations and provide support to victims.<sup>694</sup> He said that, particularly before 2004, the reception that victims of child sexual abuse received from the Victoria Police depended on the attitude of the individual member.<sup>695</sup>

We are satisfied that the Victoria Police did not properly investigate the allegation of child sexual abuse that Katherine X made in 2002.

## 5.10 Report to Victoria Police in 2008

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Katherine X told the Royal Commission that in 2005 she applied for compensation from Victims of Crime Victoria. She said that she approached the Victoria Police to make a statement to support her application for compensation, but she was not ready to press charges against her father because she was still afraid of her father and what he would do to her if he was charged.<sup>696</sup>

Katherine X gave evidence that in June 2008 she decided to have her complaints of sexual abuse by her father fully investigated by the police. She said that she made further statements to the police and gave evidence that her father was interviewed, but he denied any sexual interaction with Katherine X. Katherine X said that a DNA sample taken by the police proved that he was the father of her sons.<sup>697</sup>

The Royal Commission heard that in April 2009 Katherine X's father was charged with 83 separate charges of incest, indecent assault on a girl under 16 and common law assault. Katherine X's father pleaded guilty to 13 rolled-up charges in December 2009.<sup>698</sup>

On 15 February 2010, Katherine X's father was sentenced to a term of imprisonment of 22 years and five months, with a non-parole period of 18 years.<sup>699</sup>

Katherine X said that her interactions with the Victoria Police during this time were far more positive than her experience with the Victoria Police in 2002.<sup>700</sup>

## 6 The Department

At the public hearing, the Royal Commission heard from Dr Varughese Pradeep Philip, who was the Secretary of the Department at the time of the public hearing.

### 6.1 Acknowledgment and apology

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During the public hearing, Dr Philip made an apology on behalf of the State of Victoria to former residents who experienced sexual abuse at institutions operated by the State of Victoria. He said:<sup>701</sup>

I acknowledge that Turana, Winlaton and Baltara were institutions that were run and managed by the Department. The Department could and should have done more to protect children from the harm that they experienced as a result of unacceptable poor practices and failings whilst under the care of state.

I offer my sincere and unreserved apology to all who have been affected by these failures and unacceptable practice. I acknowledge the devastating and ongoing effects that physical and sexual abuse has on children.

Counsel for the State of Victoria submitted that there was a profound failure by the State of Victoria to protect children who were particularly vulnerable from child sexual abuse. The State acknowledged the failure of its institutions and policies, which led to or compounded the abuse suffered by children.<sup>702</sup>

The Department had a duty to care for the vulnerable children who were placed in its institutions and to protect them from sexual abuse while in the care of the Department.

We are satisfied that during the 1960s to early 1990s the Department failed to protect a number of residents of youth training and reception centres who were in the care of the Department from sexual abuse.

### 6.2 Current operation of youth justice centres in Victoria

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Today, youth justice services for children who have committed criminal acts are totally separated from out-of-home care services for children deemed in need of care and protection.<sup>703</sup>

Currently, there are two youth justice centres in operation in the State of Victoria – Parkville Youth Justice Precinct and Malmsbury Youth Justice Centre.

Dr Philip said that sexual abuse still occurs at youth justice centres and is an area that requires ongoing vigilance.<sup>704</sup> He gave evidence about current departmental policies and procedures.

## Current child protection policies and procedures

Youth justice services are overseen by various external bodies, including the Commission for Children and Young People and the Victorian Ombudsman.<sup>705</sup>

Policies and procedures currently in place at youth justice centres in Victoria include the following:

- Prospective employees of youth training centres are required to undergo various screening processes, including Working with Children checks, criminal history checks and international police checks.<sup>706</sup> Staff must also attend a four-week induction program where they learn about boundaries, sexualised behaviour, how to better understand children and de-escalation.<sup>707</sup>
- When a young person enters custody, a registered psychiatric nurse conducts a mental and physical health assessment within 24 hours to identify any health issues and safety or risk factors.<sup>708</sup> Youth Justice Custodial Services also conducts a classification process to ensure that the young person is placed in the most appropriate precinct and unit for their circumstances and development.<sup>709</sup>
- CCTV systems are present in all common areas and an automatic record is made of all doors opened at night.<sup>710</sup>
- Before a young person is released for day or weekend leave, a formal and systematic risk assessment is conducted.<sup>711</sup>
- Searches are conducted and recorded according to a formal, written procedure.<sup>712</sup>
- When a young person is returned from absconding, the most senior staff member present must meet with them to discuss the reason for absconding and offer support from the health service.<sup>713</sup>

## Current policies and procedures for reporting and responding to incidents of child sexual abuse

Dr Philip said that staff members at youth justice centres are trained to deal with and recognise children who may have been victims of sexual abuse.<sup>714</sup> Written policies and manuals also assist staff members to recognise and respond appropriately to sexualised behaviour by residents.

There are a number of mechanisms and forums for current residents of youth justice centres to raise concerns or disclose sexual abuse. These include:

- daily 'catch-ups' with key workers
- weekly 'catch-ups' with unit coordinators
- dedicated unrecorded telephone lines to the Ombudsman
- access to a broad group of people, such as professional health workers, community workers, child protection workers and visitors from the Commission for Children and Young People.<sup>715</sup>

Child sexual abuse (whether perpetrated by another resident or a staff member) is classified as a Category 1 incident – the most serious classification.<sup>716</sup> If there is an allegation of sexual abuse of a resident, staff must prepare an incident report, which must be sent to the Department as soon as possible and within one working day of the incident.<sup>717</sup>

Allegations of sexual abuse must also be reported to the police within 24 hours.<sup>718</sup> Formal policies provide that the most senior staff member in the relevant work area who was present at the time the allegation was made must call the police after ensuring that the environment is safe, preserving any forensic evidence and speaking to the resident.<sup>719</sup>

If a young person experiences sexual abuse while in custody, they are provided with counselling, support and other specialised programs depending on their needs.<sup>720</sup> Programs are also available for young people who are convicted of sexual offending or who have sexually abusive behaviours.<sup>721</sup>

We recognise that the Department has taken steps, through the implementation of policies, practices and training, to ensure that staff members at youth justice centres are able to recognise and respond appropriately to complaints of sexual abuse of residents.

## 6.3 Records

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A number of survivor witnesses gave evidence about the importance of being able to access records of their time in the care of the Department.<sup>722</sup>

Mr Stephen Hodgkinson, the Chief Information Officer of the Department, gave evidence of the extensive number of records held by the Department. He said that there are around 80 kilometres of records in the archival collection, 30 kilometres of which relate directly to former residents of state-run institutions.<sup>723</sup>

Mr Hodgkinson acknowledged the importance to survivors of having access to their records to:

- try to understand their life as a child<sup>724</sup>
- understand any cultural affiliations they may have<sup>725</sup>
- get in contact with family members<sup>726</sup>
- understand any genetic health issues<sup>727</sup>
- seek redress or compensation for sexual or physical abuse experienced as a child.<sup>728</sup>

The Royal Commission heard evidence that survivor witnesses who had sought access to their records experienced a variety of issues, including:

- delays in receiving files after making a request
- receiving heavily redacted documents
- receiving incomplete files

- files being destroyed
- receiving little or no support when files are received.

Mr Hodgkinson and Dr Philip gave evidence that addressed some or all of these issues.

## Delays

Some former residents continue to experience significant delays before receiving their ward files from the Department.

Under the relevant legislation, the Department has 45 days to respond to a request for information.<sup>729</sup>

Ms Hodgkinson, Katherine X and BDA gave evidence that they experienced significant delays between requesting and receiving all of their records from the Department.<sup>730</sup> Ms Hodgkinson said that she waited about six months after making a request to receive her Winlaton file. During this period, she had to keep chasing the Department.<sup>731</sup>

Mr Hodgkinson said that, on average, requests for ward records are dealt with within 32 days,<sup>732</sup> but delays can be experienced or files can be received in a piecemeal fashion. He said that this is due to:

- the need to consult third parties who are named in the relevant records<sup>733</sup>
- the volume of material that the Department holds<sup>734</sup>
- the complexity of the filing and indexing systems that the Department previously used,<sup>735</sup> and documents being misfiled over the years.<sup>736</sup>

Mr Hodgkinson told the Royal Commission that the Department is currently digitising all of the indexes and registers concerning care leaver records to make it easier to locate files. This process will be completed by September 2016.<sup>737</sup>

## Redactions

Many survivor witnesses gave evidence that, when they received their records, some documents were redacted.<sup>738</sup> Some survivor witnesses said that they were told that their records had been redacted to protect the personal information of other people.<sup>739</sup> Other survivor witnesses said that they were not given any explanation for why their records had been redacted.<sup>740</sup>

Mr Marijancevic, BDC and Katherine X told the Royal Commission that the redactions in the documents they received were inconsistent, as information that was disclosed in some documents was redacted in others.<sup>741</sup>

Mr Hodgkinson told the Royal Commission that the Department seeks to release as much information as possible to applicants.<sup>742</sup> However, some information cannot be disclosed under law, including personal information of persons other than the applicant and information provided in confidence (for example, during court proceedings).<sup>743</sup>

Department staff are therefore responsible for making complicated assessments about what should be redacted.<sup>744</sup> Mr Hodgkinson said that achieving consistency is a key goal and that a lot of effort is put into setting guidelines, training staff and reviewing decisions.<sup>745</sup> He recognised that, from a former resident's perspective, redaction decisions can seem unjustified or unfair and that sometimes errors are made.<sup>746</sup>

The Department provides a standard written explanation to all applicants about why documents are redacted. During oral evidence, Mr Hodgkinson accepted that it would be best practice to provide, in writing, specific rather than generic reasons for redaction decisions.<sup>747</sup> The State of Victoria submitted that templates and fact sheets were used to ensure that the Department complies with its legal obligations and give explanations that are consistent and appropriate.<sup>748</sup>

The State of Victoria also submitted that, where an application is made directly to the Department (rather than through an agent like Open Place or CLAN), departmental staff provide a verbal explanation.

Applicants may apply for review of redaction decisions.<sup>749</sup>

## Incomplete files

A number of survivor witnesses told the Royal Commission that information or documents were missing from the records they received.<sup>750</sup>

The Royal Commission heard evidence that applicants have to submit multiple requests to obtain access to all of their records if:

- the Department cannot initially locate all relevant documents<sup>751</sup>
- any of their documents are held by a non-government institution.<sup>752</sup>

The State of Victoria submitted that digitisation of indexes and registers will make it easier for the Department to locate all of the documents relevant to an applicant when an initial request is made.<sup>753</sup>

Mr Hodgkinson told the Royal Commission that the Department works closely with private institutions that hold records relating to former wards of the Department.<sup>754</sup> When documents are held by a private institution, departmental staff seek to assist applicants to locate their records.<sup>755</sup>

## Files destroyed

BDB said that she was notified by letter in 2001 that all client files for residents of Turana born before 1967 had been destroyed when the resident reached 21 years of age.<sup>756</sup> Mr Cadd recalled that while he was employed at Turana he witnessed a staff member tearing up files because they related to boys who had turned 21.<sup>757</sup>

BDF said that she was notified in 2014 that her file had been destroyed in 2003 under authority from the Public Record Office.<sup>758</sup> Katherine X said that she was informed in 2009 that ‘a second file from Winlatoon’ had been destroyed in 2002.<sup>759</sup> Mr Latham gave evidence that he was also informed that his records had been destroyed, only to be told many years later that they had not been destroyed.<sup>760</sup>

Conversely, the Royal Commission also heard evidence that some records which were meant to be retained, such as consent forms to use Depo Provera, could not be located, with the implication that they had been lost or destroyed.<sup>761</sup>

Mr Hodgkinson told the Royal Commission that before 1973 there was no legislation governing the destruction of records. Individual institutions made their own decisions about record disposal.<sup>762</sup> He said that, since 1982, ‘Record Disposal Authorities’ created by the Public Record Office have set out rules for the destruction of some categories of records relevant to former wards of the Department.<sup>763</sup> However, since October 2012, as a result of the Department’s increased understanding of the significance of records to the health and wellbeing of survivors, a ‘total destruction hold’ prohibits destruction of any records relating to departmental care.<sup>764</sup>

## Lack of support

BHE, BDF, BDB and BDA gave evidence that the Department offered them little or no support during the process of requesting and obtaining their ward files.<sup>765</sup> BHE said that she received some support through Open Place and BDF said she was assisted by Relationships Australia.<sup>766</sup>

Mr Hodgkinson told the Royal Commission that the standard of service and support that the Department provides depends on how a request is made. He said that the Department has ‘no control’ if the request is made via an agent and that in these cases the Department relies on the agent to disclose the information appropriately.<sup>767</sup> If a request is made directly to the Department, it is dealt with by staff educated about the sensitivities of providing this kind of material or by trained counsellors.<sup>768</sup>

## 7 Systemic issues

This case study provided the Royal Commission with insights into systemic issues within its Terms of Reference in the area of institutional response to concerns and allegations about incidents of child sexual abuse.

In particular, this case study raised systemic issues of:

- the vulnerability of children who are in the care of the state in a youth justice facility to being sexually abused by other residents, staff members or social workers
- the exposure of children to sexual abuse by other residents or staff members where there is a lack of adequate supervision, particularly at night
- the exposure of children to sexual abuse by other residents, staff members or social workers where staff members and social workers do not receive adequate training to recognise signs of child sexual abuse or to anticipate or deal with complaints
- the increased risk of child sexual abuse occurring where staff do not receive appropriate background checks, training and supervision
- the increased risk of child sexual abuse occurring where children deemed to be in need of care and protection are placed with children who have committed criminal offences and, similarly, where younger children are placed with older children
- the importance of staff reporting child sexual abuse to the police in order to safeguard children from further sexual abuse
- the importance of providing children with trusted adults to whom they can disclose sexual abuse
- the importance of educating and reassuring children that it is safe to report child sexual abuse and that they will receive support and assistance where they do so
- the importance of a system of independent oversight to ensure that appropriate child safe policies and procedures are in place for all children in the care of the state
- the importance of maintaining records to allow former residents to understand their life as a child and any cultural affiliations they may have and to seek redress or compensation for sexual or physical abuse they experienced as a child.



# Appendix A: Terms of Reference

## Letters Patent dated 11 January 2013

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

The Honourable Justice Peter David McClellan AM,  
Mr Robert Atkinson,  
The Honourable Justice Jennifer Ann Coate,  
Mr Robert William Fitzgerald AM,  
Dr Helen Mary Milroy, and  
Mr Andrew James Marshall Murray

GREETING

WHEREAS all children deserve a safe and happy childhood.

AND Australia has undertaken international obligations to take all appropriate legislative, administrative, social and educational measures to protect children from sexual abuse and other forms of abuse, including measures for the prevention, identification, reporting, referral, investigation, treatment and follow up of incidents of child abuse.

AND all forms of child sexual abuse are a gross violation of a child's right to this protection and a crime under Australian law and may be accompanied by other unlawful or improper treatment of children, including physical assault, exploitation, deprivation and neglect.

AND child sexual abuse and other related unlawful or improper treatment of children have a long-term cost to individuals, the economy and society.

AND public and private institutions, including child-care, cultural, educational, religious, sporting and other institutions, provide important services and support for children and their families that are beneficial to children's development.

AND it is important that claims of systemic failures by institutions in relation to allegations and incidents of child sexual abuse and any related unlawful or improper treatment of children be fully explored, and that best practice is identified so that it may be followed in the future both to protect against the occurrence of child sexual abuse and to respond appropriately when any allegations and incidents of child sexual abuse occur, including holding perpetrators to account and providing justice to victims.

AND it is important that those sexually abused as a child in an Australian institution can share their experiences to assist with healing and to inform the development of strategies and reforms that your inquiry will seek to identify.

AND noting that, without diminishing its criminality or seriousness, your inquiry will not specifically examine the issue of child sexual abuse and related matters outside institutional contexts, but that any recommendations you make are likely to improve the response to all forms of child sexual abuse in all contexts.

AND all Australian Governments have expressed their support for, and undertaken to cooperate with, your inquiry.

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the Royal Commissions Act 1902 and every other enabling power, appoint you to be a Commission of inquiry, and require and authorise you, to inquire into institutional responses to allegations and incidents of child sexual abuse and related matters, and in particular, without limiting the scope of your inquiry, the following matters:

- a. what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future;
- b. what institutions and governments should do to achieve best practice in encouraging the reporting of, and responding to reports or information about, allegations, incidents or risks of child sexual abuse and related matters in institutional contexts;
- c. what should be done to eliminate or reduce impediments that currently exist for responding appropriately to child sexual abuse and related matters in institutional contexts, including addressing failures in, and impediments to, reporting, investigating and responding to allegations and incidents of abuse;
- d. what institutions and governments should do to address, or alleviate the impact of, past and future child sexual abuse and related matters in institutional contexts, including, in particular, in ensuring justice for victims through the provision of redress by institutions, processes for referral for investigation and prosecution and support services.

AND We direct you to make any recommendations arising out of your inquiry that you consider appropriate, including recommendations about any policy, legislative, administrative or structural reforms.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to have regard to the following matters:

- e. the experience of people directly or indirectly affected by child sexual abuse and related matters in institutional contexts, and the provision of opportunities for

them to share their experiences in appropriate ways while recognising that many of them will be severely traumatised or will have special support needs;

- f. the need to focus your inquiry and recommendations on systemic issues, recognising nevertheless that you will be informed by individual cases and may need to make referrals to appropriate authorities in individual cases;
- g. the adequacy and appropriateness of the responses by institutions, and their officials, to reports and information about allegations, incidents or risks of child sexual abuse and related matters in institutional contexts;
- h. changes to laws, policies, practices and systems that have improved over time the ability of institutions and governments to better protect against and respond to child sexual abuse and related matters in institutional contexts.

AND We further declare that you are not required by these Our Letters Patent to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been, is being, or will be, sufficiently and appropriately dealt with by another inquiry or investigation or a criminal or civil proceeding.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to consider the following matters, and We authorise you to take (or refrain from taking) any action that you consider appropriate arising out of your consideration:

- i. the need to establish mechanisms to facilitate the timely communication of information, or the furnishing of evidence, documents or things, in accordance with section 6P of the Royal Commissions Act 1902 or any other relevant law, including, for example, for the purpose of enabling the timely investigation and prosecution of offences;
- j. the need to establish investigation units to support your inquiry;
- k. the need to ensure that evidence that may be received by you that identifies particular individuals as having been involved in child sexual abuse or related matters is dealt with in a way that does not prejudice current or future criminal or civil proceedings or other contemporaneous inquiries;
- l. the need to establish appropriate arrangements in relation to current and previous inquiries, in Australia and elsewhere, for evidence and information to be shared with you in ways consistent with relevant obligations so that the work of those inquiries, including, with any necessary consents, the testimony of witnesses, can be taken into account by you in a way that avoids unnecessary duplication, improves efficiency and avoids unnecessary trauma to witnesses;

- m. the need to ensure that institutions and other parties are given a sufficient opportunity to respond to requests and requirements for information, documents and things, including, for example, having regard to any need to obtain archived material.

AND We appoint you, the Honourable Justice Peter David McClellan AM, to be the Chair of the Commission.

AND We declare that you are a relevant Commission for the purposes of sections 4 and 5 of the *Royal Commissions Act 1902*.

AND We declare that you are authorised to conduct your inquiry into any matter under these Our Letters Patent in combination with any inquiry into the same matter, or a matter related to that matter, that you are directed or authorised to conduct by any Commission, or under any order or appointment, made by any of Our Governors of the States or by the Government of any of Our Territories.

AND We declare that in these Our Letters Patent:

**child** means a child within the meaning of the Convention on the Rights of the Child of 20 November 1989.

**government** means the Government of the Commonwealth or of a State or Territory, and includes any non-government institution that undertakes, or has undertaken, activities on behalf of a government.

**institution** means any public or private body, agency, association, club, institution, organisation or other entity or group of entities of any kind (whether incorporated or unincorporated), and however described, and:

- i. includes, for example, an entity or group of entities (including an entity or group of entities that no longer exists) that provides, or has at any time provided, activities, facilities, programs or services of any kind that provide the means through which adults have contact with children, including through their families; and
- ii. does not include the family.

**institutional context:** child sexual abuse happens in an institutional context if, for example:

- i. it happens on premises of an institution, where activities of an institution take place, or in connection with the activities of an institution; or

- ii. it is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where you consider that the institution has, or its activities have, created, facilitated, increased, or in any way contributed to, (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or
- iii. it happens in any other circumstances where you consider that an institution is, or should be treated as being, responsible for adults having contact with children.

**law** means a law of the Commonwealth or of a State or Territory.

**official**, of an institution, includes:

- i. any representative (however described) of the institution or a related entity; and
- ii. any member, officer, employee, associate, contractor or volunteer (however described) of the institution or a related entity; and
- iii. any person, or any member, officer, employee, associate, contractor or volunteer (however described) of a body or other entity, who provides services to, or for, the institution or a related entity; and
- iv. any other person who you consider is, or should be treated as if the person were, an official of the institution.

**related matters** means any unlawful or improper treatment of children that is, either generally or in any particular instance, connected or associated with child sexual abuse.

AND We:

- n. require you to begin your inquiry as soon as practicable, and
- o. require you to make your inquiry as expeditiously as possible; and
- p. require you to submit to Our Governor-General:
  - i. first and as soon as possible, and in any event not later than 30 June 2014 (or such later date as Our Prime Minister may, by notice in the Gazette, fix on your recommendation), an initial report of the results of your inquiry, the recommendations for early consideration you may consider appropriate to make in this initial report, and your recommendation for the date, not later than 31 December 2015, to be fixed for the submission of your final report; and

- ii. then and as soon as possible, and in any event not later than the date Our Prime Minister may, by notice in the Gazette, fix on your recommendation, your final report of the results of your inquiry and your recommendations; and
- q. authorise you to submit to Our Governor-General any additional interim reports that you consider appropriate.

IN WITNESS, We have caused these Our Letters to be made Patent.

WITNESS Quentin Bryce, Governor-General of the Commonwealth of Australia.

Dated 11th January 2013  
Governor-General  
By Her Excellency's Command  
Prime Minister

## Letters Patent dated 13 November 2014

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

The Honourable Justice Peter David McClellan AM,  
Mr Robert Atkinson,  
The Honourable Justice Jennifer Ann Coate,  
Mr Robert William Fitzgerald AM,  
Dr Helen Mary Milroy, and  
Mr Andrew James Marshall Murray

GREETING

WHEREAS We, by Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia, appointed you to be a Commission of inquiry, required and authorised you to inquire into certain matters, and required you to submit to Our Governor-General a report of the results of your inquiry, and your recommendations, not later than 31 December 2015.

AND it is desired to amend Our Letters Patent to require you to submit to Our Governor-General a report of the results of your inquiry, and your recommendations, not later than 15 December 2017.

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, amend the Letters Patent issued to you by omitting from subparagraph (p)(i) of the Letters Patent “31 December 2015” and substituting “15 December 2017”.

IN WITNESS, We have caused these Our Letters to be made Patent.

WITNESS General the Honourable Sir Peter Cosgrove AK MC (Ret'd), Governor-General of the Commonwealth of Australia.

Dated 13th November 2014  
Governor-General  
By Her Excellency's Command  
Prime Minister

## Appendix B: Public hearing

<b>The Royal Commission</b>	Justice Peter McClellan AM (Chair) Justice Jennifer Coate Mr Bob Atkinson AO APM Mr Robert Fitzgerald AM Professor Helen Milroy Mr Andrew Murray
<b>Commissioners who presided</b>	Justice Jennifer Coate Mr Robert Fitzgerald AM Mr Andrew Murray
<b>Date of hearing</b>	18 August 2015
<b>Legislation</b>	<i>Royal Commissions Act 1902</i> (Cth) <i>Evidence (Miscellaneous Provisions) Act 1958</i> (Vic)
<b>Leave to appear</b>	Norman Latham Joseph Marijancevic BDB Robert Cummings Thomas Verberne Ashley Cadd David Green BDC BHE Karen Hodgkinson Katherine X Brian Fitzgerald Jennifer Mitchell (nee Lines) Michael Groome BDF Marilyn Minister Eileen Slack BDA Stephen Fontana Stephen Hodgkinson



Varughese Pradeep Philip

BDD

Ross McIntyre

Douglas Wilkie

Gabrielle Short

Lloyd Owen

---

**Legal representation**

Dr P Dwyer, Counsel Assisting the Royal Commission

Dr M Fitzgerald, instructed by Ms E Murphy of Dr Martine Marich & Associates, appearing for BDB and BDD

C Scerri SC, L Brown and A Haban-Ber, instructed by the Victorian Government Solicitors Office, appearing for the State of Victoria

T Seccull, instructed by Dr Vivian Waller of Waller Legal, appearing for BDF

Dr M Marich of Dr Martine Marich & Associates, appearing for BDC and Karen Hodgkinson

Dr G Boas, instructed by D Dribbin of Dribbin & Brown Lawyers, appearing for Thomas Verberne and Michael Groome

C Randazzo SC, instructed by P Rankin of Peter Rankin Lawyers, appearing for Eileen Slack

A Pillay, instructed by L Kane of Waller Legal, appearing for BHE

A George of Doogue O'Brien George, appearing for Brian Fitzgerald

P Over instructed by Lewenberg and Lewenberg, appearing for Robert Cummings and Gabrielle Short

M Cahill, instructed by Lewenberg and Lewenberg, appearing for Norman Latham and BDA

P O'Brien of O'Brien Solicitors, appearing for Katherine X

S Gillespie-Jones, appearing for Joseph Marijancevic

M Mkyytowycz, instructed by P Galbally of Galbally & O'Bryan Lawyers, appearing for Ross McIntyre

M Stanton, instructed by P Galbally of Galbally & O'Bryan Lawyers, appearing for Marilyn Minister

A Kernaghan of Kernaghan & Associates, appearing for Ashley Cadd and Lloyd Owen

R Gulati, instructed by D Dribbin of Dribbin & Brown Lawyers, appearing for David Green

B Young QC, instructed by G Thomas of Barrister & Solicitor, appearing for Douglas Wilkie

D Gurvich, instructed by E Turnbull of Emma Turnbull Lawyers, appearing for Jennifer Mitchell (nee Lines)

<b>Pages of transcript</b>	1,174
<b>Notice to produce issued under <i>Royal Commissions Act 1902 (Cth)</i> and documents produced</b>	16 notices to produce, producing 31,222 documents
<b>Summons to produce documents issued under <i>Evidence (Miscellaneous Provisions) Act 1958 (Vic)</i> and documents produced</b>	45 summonses to produce, producing 10,385 documents
<b>Number of exhibits</b>	49 exhibits consisting of a total of 660 documents tendered at the hearing
<b>Witnesses</b>	<p><b>Norman Latham</b> Former resident at Turana Youth Training Centre</p> <p><b>Joseph Marijancevic</b> Former resident at Turana Youth Training Centre</p> <p><b>BDB</b> Former resident at Turana Youth Training Centre</p> <p><b>Robert Cummings</b> Former resident at Turana Youth Training Centre</p> <p><b>Thomas Verberne</b> Former psychologist at Parkville Psychiatric Unit</p>

**Ashley Cadd**

Former Youth Officer at Turana Youth Training Centre

**David Green**

Former Superintendent at Turana Youth Training Centre

**BDC**

Former resident at Winlaton Youth Training Centre

**BHE**

Former resident at Winlaton Youth Training Centre

**Karen Hodkinson**

Former resident at Winlaton Youth Training Centre

**Katherine X**

Former resident at Winlaton Youth Training Centre

**Brian Fitzgerald**

Former social worker at Department of Community Welfare Services

**Jennifer Mitchell (nee Lines)**

Former social worker at Department of Community Welfare Services

**Michael Groome**

Former senior psychiatric nurse at the Children's Court Clinic

**Gabrielle Short**

Former resident at Winlaton Youth Training Centre

**BDF**

Former resident at Winlaton Youth Training Centre

**Marilyn Minister**

Former Deputy Superintendent at Winlaton Youth Training Centre

**Dr Lloyd Owen**

Former Superintendent at Winlaton Youth Training Centre

**Dr Eileen Slack**

Former Superintendent at Winlaton Youth Training Centre

**Professor Allan Borowski**

Expert witness

**BDA**

Former resident at Baltara Reception Centre

**Grant Holland**

Former Youth and Child Care Officer at Baltara Reception Centre

**Stephen Fontana**

Assistant Commissioner of Victoria Police

**Stephen Hodgkinson**

Chief Information Officer at the Department of Health and Human Services

**Varughese Pradeep Philip**

Secretary of the Department of Health and Human Services

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# Endnotes

- 1 *Juvenile Offenders' Act 1887* (Vic); *Neglected Children's Act 1887* (Vic).
- 2 Throughout this report, children referred to as 'wards of the Department' also mean 'wards of the state' and 'state wards'.
- 3 *Children's Welfare Act 1954* (Vic) ss 3(2), 4.
- 4 *Social Welfare Act 1960* (Vic) s 3.
- 5 *Social Welfare Act 1970* (Vic) s 5.
- 6 *Community Welfare Services Act 1978* (Vic) s 6.
- 7 Victorian Government, Administrative Arrangements Order No 17 (1985), *Victoria Government Gazette*, No 21, 21 March 1985, [http://gazette.slv.vic.gov.au/view.cgi?year=1985&class=general&page\\_num=747&state=V&classNum=G21](http://gazette.slv.vic.gov.au/view.cgi?year=1985&class=general&page_num=747&state=V&classNum=G21), p 748 (viewed 25 September 2015).
- 8 *Children's Welfare Act 1954* (Vic) s 21(1); *Children's Welfare Act 1958* (Vic) s 21(1).
- 9 *Children's Welfare Act 1954* (Vic) s 12; *Social Welfare Act 1960* (Vic) ss 6–10, 55(e)(i)(c), 56; *Social Welfare Act 1970* (Vic) ss 40, 92, 105.
- 10 *Social Welfare Act 1970* (Vic) ss 36–37.
- 11 *Social Welfare Act 1970* (Vic) s 95.
- 12 Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0002\_M\_R; Government of Victoria, Submission No 173 to Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into children in institutional care*, July 2003, [www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/inst\\_care/submissions/sublist](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/inst_care/submissions/sublist), p 7 (viewed 25 September 2015).
- 13 Government of Victoria, Submission No 173 to Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into children in institutional care*, July 2003, [www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/inst\\_care/submissions/sublist](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/inst_care/submissions/sublist) p 5 (viewed 25 September 2015).
- 14 Government of Victoria, Submission No 173 to Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into children in institutional care*, July 2003, [www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/inst\\_care/submissions/sublist](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/inst_care/submissions/sublist), p 5 (viewed 25 September 2015).
- 15 Government of Victoria, Submission No 173 to Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into children in institutional care*, July 2003, [www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/inst\\_care/submissions/sublist](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/inst_care/submissions/sublist), p 5 (viewed 25 September 2015).
- 16 Find & Connect, *The Neglected and Criminal Children's Act 1864* (1864–1888), Australian Government, [www.findandconnect.gov.au/ref/vic/biogs/E000178b.htm](http://www.findandconnect.gov.au/ref/vic/biogs/E000178b.htm) (viewed 23 September 2015); *Neglected and Criminal Children's Act 1864* (Vic) ss 3, 4, 15, 16; *Juvenile Offenders' Act 1887* (Vic) s 5; *Neglected and Criminal Children's Act 1887* (Vic) ss 4-5, 13; *Children's Welfare Act 1954* (Vic) s 12; *Social Welfare Act 1960* (Vic) s 56(g); *Social Welfare Act 1970* (Vic) ss 13, 27, 92.
- 17 *Children's Welfare Act 1954* (Vic) s 12(a); S Swain, *History of institutions providing out-of-home residential care for children*, Australian Catholic University, October 2014, [www.childabuseroyalcommission.gov.au/documents/published-research/historical-perspectives-report-2-history-of-instit.pdf](http://www.childabuseroyalcommission.gov.au/documents/published-research/historical-perspectives-report-2-history-of-instit.pdf), pp 14–15 (viewed 28 September 2015).
- 18 *Social Welfare Act 1960* (Vic) s 9(1)(c); *Social Welfare Act 1970* (Vic) s 92(a).
- 19 *Social Welfare Act 1960* (Vic) s 9(1)(c); *Social Welfare Act 1970* (Vic) s 92(b).
- 20 *Children's Welfare Act 1954* (Vic) s 12(b).
- 21 S Swain, *History of institutions providing out-of-home residential care for children*, Australian Catholic University, October 2014, [www.childabuseroyalcommission.gov.au/documents/published-research/historical-perspectives-report-2-history-of-instit.pdf](http://www.childabuseroyalcommission.gov.au/documents/published-research/historical-perspectives-report-2-history-of-instit.pdf), pp 29–50 (viewed 25 September 2015).
- 22 Public Record Office Victoria, *Finding your story: A resource manual to the records of the Stolen Generations in Victoria*, State of Victoria, 2005 [http://prov.vic.gov.au/wp-content/uploads/2011/05/Finding\\_your\\_story.pdf](http://prov.vic.gov.au/wp-content/uploads/2011/05/Finding_your_story.pdf), pp 90–91 (viewed 29 September 2015).
- 23 *Children's Welfare Act 1954* (Vic) s 16.
- 24 *Children's Welfare Act 1954* (Vic) s 16(i).
- 25 Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0004\_M\_R.
- 26 Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0004\_M\_R.

- 27 Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0004\_M\_R; Transcript of K Hodkinson, Case Study 30, 20 August 2015, C9133:8–34.
- 28 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [29].
- 29 Exhibit 30-0029, 'Report prepared by A Borowski', EXP.004.001.0001\_M\_R at 0004\_M\_R.
- 30 *Children's Welfare Act 1954* (Vic) s 21(1); *Children's Welfare Act 1958* (Vic) s 21; *Social Welfare Act 1970* (Vic) ss 36, 37.
- 31 Later renamed the *Children's Court Act 1958* (Vic).
- 32 *Children's Court Act 1956* (Vic) s 28(1); *Children's Court Act 1958* (Vic) s 28(1).
- 33 *Children's Court Act 1956* (Vic) s 28(1)(f)(i); *Children's Court Act 1958* (Vic) s 28(1)(f)(i); Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0002\_M\_R.
- 34 *Children's Court Act 1956* (Vic) s 28(1)(f)(ii); *Children's Court Act 1958* (Vic) s 28(1)(f)(ii); Exhibit 30-0029, 'Report prepared by A Borowski', Case Study 30, EXP.004.001.0001\_M\_R at 0002\_M\_R.
- 35 *Children's Welfare Act 1954* (Vic) s 12(c)(ii); *Social Welfare Act 1960* (Vic) s 56(g)(ii); *Social Welfare Act 1970* (Vic) s 40(c).
- 36 *Children's Court Act 1956* (Vic) s 28(1)(h); *Children's Court Act 1958* (Vic) s 28(1)(h); *Children's Court Act 1973* (Vic) s 26(1)(g).
- 37 *Children's Court Act 1956* (Vic) s 30; *Children's Court Act 1958* (Vic) s 30; *Children's Court Act 1973* (Vic) s 28.
- 38 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [29].
- 39 Transcript of BDB, Case Study 30, 18 August 2015, C8931:21–4.
- 40 Transcript of BDB, Case Study 30, 18 August 2015, C8926:16–21.
- 41 *Community Welfare Services Act 1978* (Vic); Victorian Law Reform Commission, *Protection applications in the Children's Court*, Final Report No 19 (2010), [www.lawreform.vic.gov.au/sites/default/files/PACC\\_Chapter\\_2.pdf](http://www.lawreform.vic.gov.au/sites/default/files/PACC_Chapter_2.pdf), p 45 (viewed 25 September 2015).
- 42 Transcript of A Borowski, Case Study 30, 25 August 2015, C9571:7–25.
- 43 Government of Victoria, Submission No 173 to Senate Community Affairs References Committee, *Inquiry into children in institutional care*, July 2003, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/inst\\_care/submissions/sublist](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/inst_care/submissions/sublist), p 9 (viewed 25 September 2015).
- 44 *Neglected Children's Act 1887* (Vic) ss 19–20; *Children's Welfare Act 1954* (Vic) s 17; *Children's Welfare Act 1958* (Vic) s 17; *Social Welfare Act 1960* (Vic) s 56(l)(i); *Social Welfare Act 1970* (Vic) ss 31, 32(1).
- 45 Exhibit 30-0041, 'Statement of S Fontana', Case Study 30, STAT.0623.001.0001 at [21]–[22].
- 46 Exhibit 30-0041, 'Statement of S Fontana', Case Study 30, STAT.0623.001.0001 at [18].
- 47 Find & Connect, *Royal Park Depot* (c. 1880–1955), Australian Government, [www.findandconnect.gov.au/guide/vic/E000118](http://www.findandconnect.gov.au/guide/vic/E000118) (viewed 23 September 2015); Exhibit 30-0006, Case Study 30, DHS.3004.011.0367 at 0463.
- 48 Children's Welfare Department Victoria, *Report of the Director for the year 1955*, Government Printer, Melbourne, 1956, [www.parliament.vic.gov.au/papers/govpub/VPARL1955-56No36.pdf](http://www.parliament.vic.gov.au/papers/govpub/VPARL1955-56No36.pdf), p 4 (viewed 2 October 2015).
- 49 Exhibit 30-0013, 'Statement of D Green', Case Study 30, STAT.0627.001.0001 at [14]; Exhibit 30-0046, 'Second statement of VP Philip', Case Study 30, STAT.0626.002.0001 at [21]; Department of Community Services Victoria, *Annual report 1986–1987*, Government Printer, Melbourne, 1987, [www.parliament.vic.gov.au/papers/govpub/VPARL1987-88No61.pdf](http://www.parliament.vic.gov.au/papers/govpub/VPARL1987-88No61.pdf), p 66 (viewed 2 October 2015).
- 50 Children's Welfare Department Victoria, *Report of the Director for the year 1958*, Government Printer, Melbourne, 1959, [www.parliament.vic.gov.au/papers/govpub/VPARL1959-60No8.pdf](http://www.parliament.vic.gov.au/papers/govpub/VPARL1959-60No8.pdf), p 13 (viewed 23 September 2015).
- 51 Exhibit 30-0013, 'Statement of D Green', Case Study 30, STAT.0627.001.0001 at [17(a)]; Exhibit 30-0012, 'Statement of A Cadd', Case Study 30, STAT.0637.001.0001\_R at [11]; Exhibit 30-0011, Case Study 30, DHS.3040.0003.0007.
- 52 Exhibit 30-0013, 'Statement of D Green', Case Study 30, STAT.0627.001.0001 at [17(b)]; Exhibit 30-0012, 'Statement of A Cadd', Case Study 30, STAT.0637.001.0001\_R at [11]; Exhibit 30-0011, Case Study 30, DHS.3040.0003.0007.
- 53 Exhibit 30-0013, 'Statement of D Green', Case Study 30, STAT.0627.001.0001 at [17(c)]; Exhibit 30-0012, 'Statement of A Cadd', Case Study 30, STAT.0637.001.0001\_R at [11]; Exhibit 30-0011, Case Study 30, DHS.3040.0003.0007.
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- 60 Exhibit 30-0006, Case Study 30, DHS.3004.011.0367 at 0468.
- 61 Exhibit 30-0006, Case Study 30, DHS.3004.011.0367 at 0468; Children’s Welfare Department Victoria, *Report of the Director for the year 1956*, Government Printer, Melbourne, 1957, [www.parliament.vic.gov.au/papers/govpub/VPARL1956-58No25.pdf](http://www.parliament.vic.gov.au/papers/govpub/VPARL1956-58No25.pdf), p 11 (viewed 28 September 2015).
- 62 Exhibit 30-0011, Case Study 30, DHS.3004.001.0010 at 0034–0035.
- 63 Exhibit 30-0011, Case Study 30, DHS.3106.005.0006 at 0011.
- 64 Exhibit 30-0011, Case Study 30, DHS.3004.001.0010 at 0033.
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- 67 Exhibit 30-0006, Case Study 30, DHS.3004.011.0367 at 0468.
- 68 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0005; Exhibit 30-0011, Case Study 30, DHS.3004.001.0010 at 0027.
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- 76 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [19]–[20].
- 77 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [21].
- 78 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [23].
- 79 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [22].
- 80 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [25]; Transcript of G Holland, Case Study 30, 26 August 2015, C9737:12–21.
- 81 Transcript of G Holland, Case Study 30, 26 August 2015, C9732:40–C9733:6; Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [12], [14].
- 82 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [15].
- 83 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [16].
- 84 Exhibit 30-0006, Case Study 30, DHS.3004.011.0367 at 0386–0387.
- 85 Exhibit 30-0003, ‘Statement of BDB’, Case Study 30, STAT.0609.001.0001\_R at [94]–[97]; Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [88].
- 86 Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [90].
- 87 Exhibit 30-0003, ‘Statement of BDB’, Case Study 30, STAT.0609.001.0001\_R at [7]–[10]; Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0002\_R; Exhibit 30-0044, ‘Statement of BHU’, Case Study 30, STAT.0653.001.0001\_M\_R at [6]; Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [7]–[12].

- 88 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [12]–[13], [17]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [15]; Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [19]–[27]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [11]–[14].
- 89 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [2]; Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [7]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [9]; Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [7]; Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [11]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [7]; Exhibit 30-0043, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0002\_R; Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [12]–[15]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [7]–[10].
- 90 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [9].
- 91 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [15]–[17].
- 92 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [10]; Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [15]–[17]; Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [15]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [11]; Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [10]–[11].
- 93 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [29]; Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [22]; Exhibit 30-0004, 'Statement of R Cummings', STAT.0608.001.0001\_R\_M at [16]; Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [20].
- 94 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [12].
- 95 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [15]–[20]; Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [17]–[18].
- 96 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [19], [44]; Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [8]–[9], [18], [21]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [3]–[5], [10]–[15]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [11]–[14]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [15].
- 97 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [27]–[28]; Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [19]–[23], [34]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [30]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [63]–[69]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [6]–[7]; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [10]–[15], [23], [28].
- 98 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [34], [36], [41]; Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [36]–[39]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [52]–[53]; Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [22]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [15]; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [30].
- 99 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [35].
- 100 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [39], [43]–[44], [55], [75].
- 101 Transcript of N Latham, Case Study 30, 17 August 2015, C8869:2–6; Submissions of D Wilkie, Case Study 30, SUBM.1030.021.0001 at [1]–[3];
- 102 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [73]–[74].
- 103 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [44]–[52].
- 104 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [44]–[52].
- 105 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [62]–[70], [83]–[90].
- 106 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [63]–[65].
- 107 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [67].
- 108 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [68]–[71].



109 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [86].  
110 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [87]–[90].  
111 Transcript of BDB, Case Study 30, 18 August 2015, C8920:21–43.  
112 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [27].  
113 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [32], [39].  
114 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [44]–[45].  
115 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [46].  
116 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [47]–[48].  
117 Transcript of BDB, Case Study 30, 18 August 2015, C8922:14–25.  
118 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [18]–[23].  
119 Exhibit 30-0049, 'Further Statement of BDD', Case Study 30, STAT.0620.002.0001\_R at [5]–[9].  
120 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [43]; Exhibit 30-0049,  
'Further Statement of BDD', Case Study 30, STAT.0620.002.0001\_R at [16]–[17].  
121 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [46].  
122 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [46]–[47]; Exhibit 30-0049,  
'Further Statement of BDD', Case Study 30, STAT.0620.002.0001\_R at [18].  
123 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [27].  
124 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [30]–[45], [52]–  
[54], [61]–[64].  
125 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [79]–[80].  
126 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [94].  
127 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [95]–[96].  
128 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_M\_R at [121].  
129 Exhibit 30-0044, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0002\_R.  
130 Exhibit 30-0044, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0003\_R.  
131 Exhibit 30-0044, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0002\_R–0003\_R.  
132 Exhibit 30-0044, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0003\_R.  
133 Exhibit 30-0044, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0003\_R.  
134 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [23]–[24].  
135 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [31]–[35].  
136 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [35].  
137 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [27], [49].  
138 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [73].  
139 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [78].  
140 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [82]–[89].  
141 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [27]–[29].  
142 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [34], [39]–[41].  
143 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [34]–[35].  
144 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [39].  
145 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [46]–[47].  
146 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [15]–[16].  
147 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [40].  
148 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [51]–[54].  
149 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [12].  
150 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [30], [33].  
151 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [33].  
152 Transcript of BHE, Case Study 30, 19 August 2015, C9117:43–C9118:5.  
153 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [37], [39].  
154 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [41]–[43].  
155 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [46].  
156 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [17]–[20].  
157 The Royal Commission made a number of enquiries to locate Mr Paul Yew for the public hearing, but were  
unable to confirm his whereabouts.  
158 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [35]–[38].  
159 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [40].

- 160 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [45]–[46].
- 161 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [48].
- 162 Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [30].
- 163 Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [31]–[35].
- 164 Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [36]–[44].
- 165 Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [45].
- 166 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [27].
- 167 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [35]–[36].
- 168 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [37].
- 169 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [40].
- 170 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [44].
- 171 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [45].
- 172 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [67].
- 173 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [59]; Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [29]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [22], [68]–[72], Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [87].
- 174 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [69].
- 175 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [27]–[28], [36], [58]–[59].
- 176 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [40], [45]–[46].
- 177 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [48]–[51]; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [31]–[35].
- 178 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [56].
- 179 Exhibit 30-0043, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0002\_R.
- 180 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [102]; Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [60]–[61].
- 181 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [30]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [22].
- 182 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [36], [60]–[64].
- 183 Transcript of L Owen, Case Study 30, 25 August 2015, C9510:1–16; Transcript of M Minister, Case Study 30, 24 August 2015, C9391:8–22; Transcript of E Slack, Case Study 30, 26 August 2015, C9616:20–5.
- 184 Transcript of L Owen, Case Study 30, 25 August 2015, C9510:5–16; Transcript of M Minister, Case Study 30, 24 August 2015, C9391:30–42; Transcript of E Slack, Case Study 30, 26 August 2015, C9616:20–5; C9617:5–11.
- 185 Transcript of L Owen, Case Study 30, 25 August 2015, C9510:31–6; Transcript of E Slack, Case Study 30, 26 August 2015, C9616:27–30.
- 186 Transcript of M Minister, Case Study 30, 24 August 2015, C9391:24–8.
- 187 Transcript of BDC, Case Study 30, 19 August 2015, C9107:38–C9108:10; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [58].
- 188 Transcript of K Hodkinson, Case Study 30, 20 August 2015, C9135:5–20.
- 189 Transcript of A Cadd, Case Study 30, 19 August 2015, C9033:4–23.
- 190 Transcript of R Cummings, Case Study 30, 18 August 2015, C8953:30–47; Transcript of J Marijancevic, Case Study 30, 18 August 2015, C8902:13–31.
- 191 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [35].
- 192 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0094–0095.
- 193 Transcript of A Cadd, Case Study 30, 19 August 2015, C9032:41–C9033:2.
- 194 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [57]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [17]–[19], [36]–[38]; Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [13]–[15].
- 195 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [57].
- 196 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [13].
- 197 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [36]–[38].
- 198 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [17]–[19].
- 199 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [15]; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [57].
- 200 Transcript of E Slack, Case Study 30, 26 August 2015, C9613:29–35.

- 201 Transcript of E Slack, Case Study 30, 26 August 2015, C9657:33–5.
- 202 Transcript of M Minister, Case Study 30, 24 August 2015, C9404:25–37.
- 203 Transcript of M Minister, Case Study 30, 24 August 2015, C9405:40–4; C9408:46–C9409:11.
- 204 Transcript of M Minister, Case Study 30, 24 August 2015, C9405:46–C9406:1; C9409:13–14.
- 205 Transcript of M Minister, Case Study 30, 24 August 2015, C9409:30–3.
- 206 Transcript of M Minister, Case Study 30, 24 August 2015, C9409:16–38.
- 207 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0105; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0079.
- 208 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0129; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0117.
- 209 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [51]–[52]; Transcript of BDC, Case Study 30, 19 August 2015, C9106:42–C9107:1; Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [24]; Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [50]; Transcript of K Hodgkinson, Case Study 30, 20 August 2015, C9134:5–29.
- 210 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [51]–[54].
- 211 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [55].
- 212 Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [25]; Transcript of K Hodgkinson, Case Study 30, 20 August 2015, C9134:37–41.
- 213 Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [26]; Transcript of K Hodgkinson, Case Study 30, 20 August 2015, C9134:37–41; Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [24].
- 214 Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [28].
- 215 Transcript of BDC, Case Study 30, 19 August 2015, C9107:18–29.
- 216 Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [50].
- 217 Transcript of K Hodgkinson, Case Study 30, 20 August 2015, C9134:5–10.
- 218 Transcript of K Hodgkinson, Case Study 30, 20 August 2015, C9134:24–9.
- 219 Transcript of M Minister, Case Study 30, 24 August 2015, C9401:10–13.
- 220 Transcript of M Minister, Case Study 30, 24 August 2015, C9402:35–9.
- 221 Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [59].
- 222 Transcript of BDB, Case Study 30, 18 August 2015, C8931:40–5.
- 223 Exhibit 30-0001, ‘Statement of N Latham’, Case Study 30, STAT.0611.001.0001\_R at [94]; Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [75]; Exhibit 30-0042, ‘Statement of BDD’ Case Study 30, STAT.0620.001.0001\_M\_R at [80]; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [108]; Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [87]; Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0004\_R–0005\_R.
- 224 Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [113]; Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [86]; Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [56], [58]; Exhibit 30-0042, ‘Statement of BDD’, Case Study 30, at [75]–[76]; Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0004\_R.
- 225 Exhibit 30-0001, ‘Statement of N Latham’, Case Study 30, STAT.0611.001.0001\_R at [98]–[99]; Transcript of J Marijancevic, Case Study 30, 18 August 2015, C8908:5–11; Exhibit 30-0003, ‘Statement of BDB’, Case Study 30, STAT.0609.001.0001\_R at [74]; Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [60]; Exhibit 30-0044, ‘Statement of BHU’, Case Study 30, STAT.0653.001.0001\_M\_R at [67]–[70].
- 226 Transcript of BDB, Case Study 30, 18 August 2015, C8928:20–C8929:1; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [112]–[113]; Exhibit 30-0042, ‘Statement of BDD’, Case Study 30, STAT.0620.001.0001\_M\_R at [77].
- 227 Exhibit 30-0003, ‘Statement of BDB’, Case Study 30, STAT.0609.001.0001\_R at [84]–[86]; Transcript of R Cummings, Case Study 30, 18 August 2015, C8956:22–33; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [112]; Transcript of BHE, Case Study 30, 19 August 2015, C9117:17–27; Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [55]; Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [76]–[77]; Exhibit 30-0042, ‘Statement of BDD’, Case Study 30, STAT.0620.001.0001\_M\_R at [79]; Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0004\_R–0005\_R.

- 228 Exhibit 30-0045, 'Further statement of N Latham', Case Study 30, STAT.0611.002.0001\_R at [4]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [74]; Exhibit 30-0043, 'Statement of W Clark', Case Study 30, STAT.0642.001.0001\_R at 0004\_R.
- 229 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [115]; Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [90]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [78]; Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [78]; Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [67].
- 230 Transcript of BDC, Case Study 30, 19 August 2015, C9108:21-4; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [67]; Exhibit 30-0044, 'Statement of BHU' Case Study 30, STAT.0653.001.0001\_M\_R at [69], [73].
- 231 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [42].
- 232 Exhibit 30-0044, 'Statement of BHU', Case Study 30, STAT.0653.001.0001\_M\_R at [45]; Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [40].
- 233 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [40].
- 234 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [65]; Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [79]-[80].
- 235 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [35].
- 236 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [42].
- 237 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [88].
- 238 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [76].
- 239 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [98]-[101].
- 240 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [43].
- 241 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [44].
- 242 Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [47]-[49].
- 243 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [70].
- 244 Enquiries made by the Royal Commission confirmed that Mr Ian Cox died in 2008.
- 245 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [73].
- 246 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [74]-[75].
- 247 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [50].
- 248 Exhibit 30-0042, 'Statement of BDD', Case Study 30, STAT.0620.001.0001\_M\_R at [51].
- 249 Exhibit 30-0001, 'Statement of N Latham', Case Study 30, STAT.0611.001.0001\_R at [89]-[90].
- 250 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [91]; Exhibit 30-0016, 'Statement of K Hodkinson', Case Study 30, STAT.0614.001.0001\_R at [47]; Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [101]; Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [44].
- 251 Transcript of M Minister, Case Study 30, 24 August 2015, C9423:2-28.
- 252 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [57]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [43]; Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [54]; Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [50]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [38].
- 253 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [39], [44].
- 254 Transcript of BDF, Case Study 30, 21 August 2015, C9351:28-35.
- 255 Exhibit 30-0023, 'Statement of G Short', Case Study 30, STAT.0647.001.0001\_M\_R at [54].
- 256 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [50]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [38], [88].
- 257 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [50]; Submission of BDB, Case Study 30, SUBM.1030.008.0001 at [6(a)], [7]-[9].
- 258 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [38].
- 259 Transcript of L Owen, Case Study 30, 25 August 2015, C9512:41-C9513:9; Transcript of E Slack, Case Study 30, 26 August 2015, C9654:47-C9655:7; Transcript of M Minister, Case Study 30, 24 August 2015, C9416:35-45; Transcript of A Cadd, Case Study 30, 19 August 2015, C9014:13-28; Transcript of AD Green, Case Study 30, 19 August 2015, C9066:4-31; Transcript of G Holland, Case Study 30, 26 August 2015, C9758:11-39.

260 Transcript of AD Green, Case Study 30, 19 August 2015, C9066:13–27; Transcript of G Holland, Case Study 30, 26 August 2015, C9758:11–39.

261 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [101]; Exhibit 30-0002, ‘Statement of J Marijanecvic’, Case Study 30, STAT.0610.001.0001\_R at [91], [99]; Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [55]; Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [44]; Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0002\_R, 0004\_R.

262 Exhibit 30-0002, ‘Statement of J Marijanecvic’, Case Study 30, STAT.0610.001.0001\_R at [91].

263 Exhibit 30-0043, ‘Statement of W Clark’, Case Study 30, STAT.0642.001.0001\_R at 0004\_R.

264 Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [56].

265 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [37].

266 Transcript of L Owen, Case Study 30, 25 August 2015, C9500:3–C9501:5.

267 Transcript of L Owen, Case Study 30, 25 August 2015, C9501:18–22.

268 Transcript of G Holland, Case Study 30, 26 August 2015, C9741:29–47.

269 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [47], [54]; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [60].

270 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [47].

271 Exhibit 30-0029, ‘Report prepared by A Borowski’, Case Study 30, EXP.004.001.0001\_M\_R at 0002\_M\_R.

272 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [37].

273 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [43].

274 Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [38], [48], [54], [60].

275 Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [117].

276 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [33]; Transcript of A Cadd, Case Study 30, 19 August 2015, C9022:22–35.

277 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [52]–[54].

278 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [34]–[38].

279 Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001\_R at [45]; Transcript of A Borowski, Case Study 30, 25 August 2015, C9566:9–34.

280 Transcript of BDB, Case Study 30, 18 August 2015, C8922:27–35.

281 Transcript of BDB, Case Study 30, 18 August 2015, C8932:4–12.

282 Transcript of AD Green, Case Study 30, 19 August 2015, C9054:14–18.

283 Transcript of A Cadd, Case Study 30, 19 August 2015, C9032:41–6.

284 Transcript of L Owen, Case Study 30, 25 August 2015, C9526:38–43.

285 Transcript of L Owen, Case Study 30, 25 August 2015, C9526:25–36.

286 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [57].

287 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [55].

288 Transcript of A Cadd, Case Study 30, 19 August 2015, C9018:19–C9019:6.

289 Transcript of AD Green, Case Study 30, 19 August 2015, C9074:31–40.

290 Transcript of L Owen, Case Study 30, 25 August 2015, C9498:27–C9499:14.

291 Transcript of E Slack, Case Study 30, 26 August 2015, C9602:12–26; Transcript of M Minister, Case Study 30, 24 August 2015, C9415:41–C9416:9.

292 Transcript of E Slack, Case Study 30, 26 August 2015, C9603:20–34.

293 Transcript of M Minister, Case Study 30, 24 August 2015, C9422:3–10.

294 Transcript of M Minister, Case Study 30, 24 August 2015, C9393:25–8.

295 Transcript of M Minister, Case Study 30, 24 August 2015, C9437:30–8.

296 Transcript of G Holland, Case Study 30, 26 August 2015, C9734:19–45.

297 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [36].

298 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [37].

299 Transcript of V Philip, Case Study 30, 28 August 2015, C9953:3–26.

300 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0627.001.0001 at [64(h)].

301 Transcript of E Slack, Case Study 30, 26 August 2015, C9644:3–21.

302 Exhibit 30-001, Case Study 30, DHS.3004.003.0001; Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [43]; Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001\_R at [57]–[58].

303 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [43].

304 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0059–0062.  
305 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0032.  
306 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0094–0097.  
307 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0069–0077.  
308 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [48]–[49].  
309 Transcript of A Cadd, Case Study 30, 19 August 2015, C9049:6–24.  
310 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [60].  
311 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [59]–[60]. Transcript of A Cadd, Case Study 30, 19 August 2015, C9012:11–26.  
312 Exhibit 30-0046, ‘Second statement of VP Philip’, Case Study 30, STAT.0626.002.0001 at [49]–[50].  
313 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [50]–[52].  
314 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [53]–[54].  
315 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [45].  
316 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [48].  
317 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [49]; Transcript of G Holland, Case Study 30, 26 August 2015, C9748:13–28.  
318 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078.  
319 Exhibit 30-0011, Case Study 30, DHS.3127.002.0019.  
320 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0120–0122; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0101–0107.  
321 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0118–0119; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0147–0149.  
322 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0105; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0125.  
323 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0129; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0080.  
324 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0102–0105, 0113; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0075–0079.  
325 Transcript of L Owen, Case Study 30, 25 August 2015, C9496:7–12, C9497:31–5.  
326 Transcript of E Slack, Case Study 30, 26 August 2015, C9640:5–21.  
327 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0118–0119.  
328 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0118.  
329 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0118.  
330 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0119.  
331 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0119.  
332 Transcript of E Slack, Case Study 30, 26 August 2015, C9643:25–36.  
333 Transcript of E Slack, Case Study 30, 26 August 2015, C9643:38–41.  
334 Transcript of M Minister, Case Study 30, 24 August 2015, C9469:39–42.  
335 Exhibit 30-0011, Case Study 30, DHS.3017.002.0019.  
336 Submissions of the State of Victoria, SUBM.1030.017.0001 at [15].  
337 Exhibit 30-0011, Case Study 30, DHS.3089.004.0003; Exhibit 30-0011, Case Study 30, DHS.3068.0005.0049.  
338 Transcript of A Cadd, Case Study 30, 19 August 2015, C9011:11–26.  
339 Transcript of A Cadd, Case Study 30, 19 August 2015, C9014:40–C9015:7, C9032:23–39.  
340 Transcript of A Cadd, Case Study 30, 19 August 2015, C9019:12–29.  
341 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [40].  
342 Transcript of AD Green, Case Study 30, 19 August 2015, C9053:23–44; Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001 at [6]; Transcript of A Cadd, Case Study 30, 19 August 2015, C9009:29–32; Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9171:34–7; Transcript of G Holland, Case Study 30, 26 August 2015, C9728:19–23.  
343 Transcript of G Holland, Case Study 30, 26 August 2015, C9739:1–20; Transcript of M Minister, Case Study 30, 24 August 2015, C9485:9–15; Transcript of AD Green, Case Study 30, 19 August 2015, C9067:29–C9068:5.  
344 Transcript of AD Green, Case Study 30, 19 August 2015, C9067:29–C9068:5.  
345 Transcript of AD Green, Case Study 30, 19 August 2015, C9056:26–9; Transcript of M Minister, Case Study 30, 24 August 2015, C9484:41–C9485:22.

346 Exhibit 30-0012, 'Statement of A Cadd', Case Study 30, STAT.0637.001.0001\_R at [40]–[42]; Transcript of A  
Cadd, Case Study 30, 19 August 2015, C9012:11–32; Exhibit 30-0018, 'Statement of B Fitzgerald', Case Study  
30, STAT.0621.001.0001\_R at [6]; Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9173:11–31.

347 Transcript of G Holland, Case Study 30, 26 August 2015, C9728:45–C9729:14, 28–40; Transcript of G  
Holland, Case Study 30, 27 August 2015, C9765:33–C9766:8.

348 Transcript of A Cadd, Case Study 30, 19 August 2015, C9012:11–32.

349 Transcript of AD Green, Case Study 30, 19 August 2015, C9054:28–C9055:21.

350 Exhibit 30-0038, 'Statement of G Holland', Case Study 30, STAT.0638.001.0001 at [11]; Transcript of G  
Holland, Case Study 30, 26 August 2015, C9731:15–30; Transcript of G Holland, Case Study 30, 27 August  
2015, C9763:4–14.

351 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0114; Exhibit 30-0011, Case Study 30,  
DHS.3128.003.0012 at 0017; Transcript of M Minister, Case Study 30, 24 August 2015, C9383:39–C9384:11;  
Exhibit 30-0038, 'Statement of G Holland', Case Study 30, STAT.0638.001.0001 at [29].

352 Transcript of AD Green, Case Study 30, 19 August 2015, C9054:28–C9055:21.

353 Transcript of A Cadd, Case Study 30, 19 August 2015, C9042:20–9.

354 Transcript of G Holland, Case Study 30, 26 August 2015, C9734:26–45, C9737:23–30.

355 Transcript of G Holland, Case Study 30, 26 August 2015, C9735:27–C9736:1.

356 Transcript of G Holland, Case Study 30, 26 August 2015, C9735:39–C9736:1.

357 Transcript of V Philip, Case Study 30, 28 August 2015, C9938:27–37.

358 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [44]–[45]; Exhibit 30-0022,  
'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [35]–[36].

359 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [43].

360 Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [46]–[48].

361 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [37].

362 Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [35]–[36].

363 Exhibit 30-0036, Annexure BDA-6, Case Study 30, DHS.3002.089.0004\_R at 0004\_R.

364 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [66].

365 Exhibit 30-0004, 'Statement of R Cummings', Case Study 30, STAT.0608.001.0001\_R\_M at [96].

366 Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [45]–[46].

367 Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [35], [39]–[40].

368 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [43].

369 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0061–0062.

370 Transcript of M Minister, Case Study 30, 24 August 2015, C9414:29–44; Exhibit 30-0038, 'Statement of G  
Holland', Case Study 30, STAT.0638.001.0001 at [33]–[34]; Transcript of G Holland, Case Study 30, 26 August  
2015, C9738:5–20.

371 Transcript of AD Green, Case Study 30, 19 August 2015, C9062:46–C9063:11.

372 Transcript of A Cadd, Case Study 30, 19 August 2015, C9016:28–C9017:24.

373 Transcript of M Minister, Case Study 30, 24 August 2015, C9415:5–25.

374 Transcript of A Cadd, Case Study 30, 19 August 2015, C9016:28–39; Transcript of M Minister, Case  
Study 30, 24 August 2015, C9414:29–44; Exhibit 30-0038, 'Statement of G Holland', Case Study 30,  
STAT.0638.001.0001 at [33]–[34]; Transcript of G Holland, Case Study 30, 26 August 2015, C9738:5–20.

375 Transcript of AD Green, Case Study 30, 19 August 2015, C9061:13–21.

376 Transcript of AD Green, Case Study 30, 19 August 2015, C9060:17–37.

377 Transcript of AD Green, Case Study 30, 19 August 2015, C9059:44–C9061:28.

378 Transcript of E Slack, Case Study 30, 26 August 2015, C9656:37–C9657:2.

379 Transcript of AD Green, Case Study 30, 19 August 2015, C9059:20–42, C9061:13–21; Exhibit 30-0030,  
'Statement of L Owen', Case Study 30, STAT.0652.002.0001\_R at [20]; Transcript of E Slack, Case Study 30, 26  
August 2015, C9656:33–5; Transcript of G Holland, Case Study 30, 27 August 2015, C9764:1–14.

380 Transcript of AD Green, Case Study 30, 19 August 2015, C9062:46–C9063:11.

381 Transcript of AD Green, Case Study 30, 19 August 2015, C9063:13–19.

382 Transcript of A Cadd, Case Study 30, 19 August 2015, C9016:28–C9017:24.

383 Transcript of M Minister, Case Study 30, 24 August 2015, C9414:3–9.

384 Transcript of L Owen, Case Study 30, 25 August 2015, C9512:34–9.

385 Transcript of G Holland, Case Study 30, 27 August 2015, C9764:1–C9765:6.

386 Transcript of G Holland, Case Study 30, 27 August 2015, C9764:1–14.

- 387 Transcript of A Cadd, Case Study 30, 19 August 2015, C9042:20–9.
- 388 Transcript of AD Green, Case Study 30, 19 August 2015, C9055:2–21, C9078:20–43.
- 389 Transcript of A Cadd, Case Study 30, 19 August 2015, C9016:28–39.
- 390 Transcript of A Cadd, Case Study 30, 19 August 2015, C9042:31–7.
- 391 Transcript of A Cadd, Case Study 30, 19 August 2015, C9029:43–C9030:30.
- 392 Exhibit 30-0013, ‘Statement of AD Green’, Case Study 30, STAT.0627.001.0001 at [43].
- 393 Transcript of AD Green, Case Study 30, 19 August 2015, C9055:23–31; Transcript of A Cadd, Case Study 30, 19 August 2015, C9030:4–11; Exhibit 30-0030, ‘Statement of L Owen’, Case Study 30, STAT.0652.002.0001\_R at [64]; Transcript of E Slack, Case Study 30, 26 August 2015, C9619:39–C9620:5; Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [26]–[27].
- 394 Transcript of AD Green, Case Study 30, 19 August 2015, C9055:2–21; Transcript of A Cadd, Case Study 30, 20 August 2015, C9042:20–9; Exhibit 30-0030, ‘Statement of L Owen’, Case Study 30, STAT.0652.002.0001\_R at [64]; Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [26]–[27]; Transcript of G Holland, Case Study 30, 26 August 2015, C9736:26–43.
- 395 Transcript of A Cadd, Case Study 30, 19 August 2015, C9033:47–C9034:9; Transcript of AD Green, Case Study 30, 19 August 2015, C9059:20–42; Transcript of E Slack, Case Study 30, 26 August 2015, C9654:37–45; Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [35]; Transcript of G Holland, Case Study 30, 26 August 2015, C9738:22–42, C9741:24–7; Transcript of V Philip, Case Study 30, 26 August 2015, C9938:45–C9939:8.
- 396 Transcript of A Cadd, Case Study 30, 19 August 2015, C9011:46–C9012:9; Transcript of AD Green, Case Study 30, 19 August 2015, C9056:31–4; Transcript of M Minister, Case Study 30, 24 August 2015, C9461:43–C9462:6; Transcript of G Holland, Case Study 30, 27 August 2015, C9758:41–C9759:2.
- 397 Transcript of A Cadd, Case Study 30, 19 August 2015, C9011:46–C9012:9; Transcript of AD Green, Case Study 30, 19 August 2015, C9056:43–C9057:6; Exhibit 30-0013, ‘Statement of AD Green’, Case Study 30, STAT.0627.001.0001 at [23]–[28]; Transcript of M Minister, Case Study 30, 24 August 2015, C9417:42–C9418:3, C9462:23–4.
- 398 Transcript of A Cadd, Case Study 30, 19 August 2015, C9011:46–C9012:9.
- 399 Transcript of M Minister, Case Study 30, 24 August 2015, C9461:43–C9462:26, C9470:20–6.
- 400 Transcript of M Minister, Case Study 30, 24 August 2015, C9461:9–41.
- 401 Transcript of AD Green, Case Study 30, 19 August 2015, C9064:39–C9065:15.
- 402 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [64(a)]–[64(b)]; Transcript of A Cadd, Case Study 30, 19 August 2015, C9010:25–35, C9037:3–5.
- 403 Transcript of A Cadd, Case Study 30, 19 August 2015, C9010:25–35.
- 404 Transcript of A Cadd, Case Study 30, 19 August 2015, C9021:14–29.
- 405 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [50]; see also Transcript of G Holland, Case Study 30, 26 August 2015, C9749:13–44.
- 406 Transcript of G Holland, Case Study 30, 26 August 2015, C9750:7–16.
- 407 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [50]; see also Transcript of G Holland, Case Study 30, 26 August 2015, C9749:16–44.
- 408 Transcript of A Cadd, Case Study 30, 19 August 2015, C9036:14–24.
- 409 Transcript of G Holland, Case Study 30, 27 August 2015, C9758:41–C9759:19.
- 410 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [57]; Transcript of G Holland, Case Study 30, 26 August 2015, C9744:21–39, C9750:35–C9751:17.
- 411 Transcript of AD Green, Case Study 30, 19 August 2015, C9061:30–C9062:1, C9064:12–16.
- 412 Transcript of AD Green, Case Study 30, 19 August 2015, C9064:18–37.
- 413 Transcript of AD Green, Case Study 30, 19 August 2015, C9064:22–37.
- 414 Exhibit 30-0013, ‘Statement of AD Green’, Case Study 30, STAT.0627.001.0001 at [32]; Transcript of AD Green, Case Study 30, 19 August 2015, C9057:8–11, C9057:37–40.
- 415 Transcript of AD Green, Case Study 30, 19 August 2015, C9057:47–C9058:23, C9066:33–44.
- 416 Transcript of M Minister, Case Study 30, 24 August 2015, C9389:1–8; Transcript of L Owen, Case Study 30, 25 August 2015, C9508:39–C9509:6; Exhibit 30-0034, ‘Statement of E Slack’, Case Study 30, STAT.0630.001.0001\_R at [21]; Transcript of E Slack, Case Study 30, 26 August 2015, C9600:8–33.
- 417 Transcript of E Slack, Case Study 30, 26 August 2015, C9602:12–26; Transcript of M Minister, Case Study 30, 24 August 2015, C9415:41–C9416:9.
- 418 Transcript of E Slack, Case Study 30, 26 August 2015, C9603:20–34.



- 419 Transcript of E Slack, Case Study 30, 26 August 2015, C9602:46–C9603:34.
- 420 Transcript of E Slack, Case Study 30, 26 August 2015, C9649:5–19; Transcript of E Slack, Case Study 30, 26 August 2015, C9631:39–C9632:28.
- 421 Transcript of E Slack, Case Study 30, 26 August 2015, C9632:12–15, C9660:25–39.
- 422 Exhibit 30-0034, ‘Statement of E Slack’, Case Study 30, STAT.0630.001.0001\_R at [61].
- 423 Exhibit 30-0034, ‘Statement of E Slack’, Case Study 30, STAT.0630.001.0001\_R at [61]–[62]; Transcript of E Slack, Case Study 30, 26 August 2015, C9658:5–9.
- 424 Transcript of E Slack, Case Study 30, 26 August 2015, C9632:2–10, C9702:11–21.
- 425 Transcript of E Slack, Case Study 30, 26 August 2015, C9661:41–4.
- 426 Exhibit 30-0034, ‘Statement of E Slack’, Case Study 30, STAT.0630.001.0001\_R at [62].
- 427 Submissions of M Minister, SUBM.1030.006.0001 at [19]–[25].
- 428 Transcript of E Slack, Case Study 30, 26 August 2015, C9686:42–C9687:8.
- 429 Submissions of M Minister, SUBM.1030.006.0001 at [21(6)].
- 430 Submissions of M Minister, SUBM.1030.006.0001 at [20], [23].
- 431 Further Submissions of E Slack, SUBM.1030.012.0013 at [4]–[6].
- 432 Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001 at [48].
- 433 Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001 at [49]–[50].
- 434 Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001 at [40]–[41].
- 435 Exhibit 30-0013, ‘Statement of D Green’, Case Study 30, STAT.0627.001.0001 at [42].
- 436 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [39].
- 437 Transcript of G Holland, Case Study 30, 26 August 2015, C9752:29–C9753:6.
- 438 Transcript of G Holland, Case Study 30, 26 August 2015, C9753:8–17.
- 439 Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [52]–[54].
- 440 Transcript of G Holland, Case Study 30, 26 August 2015, C9752:14–27; Exhibit 30-0038, ‘Statement of G Holland’, Case Study 30, STAT.0638.001.0001 at [52]–[54].
- 441 Transcript of AD Green, Case Study 30, 19 August 2015, C9080:3–15.
- 442 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [54].
- 443 Transcript of G Holland, Case Study 30, 26 August 2015, C9743:17–33.
- 444 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0018–0019.
- 445 Transcript of E Slack, Case Study 30, 26 August 2015, C9640:39–C9641:23, C9641:36–C9642:38.
- 446 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0108.
- 447 Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0080.
- 448 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [76].
- 449 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [79]; Transcript of R Cummings, Case Study 30, 18 August 2015, C8954:37–40.
- 450 Transcript of R Cummings, Case Study 30, 18 August 2015, C8954:6–13.
- 451 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [80].
- 452 Transcript of T Verberne, Case Study 30, 18 August 2015, C8974:13–34.
- 453 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [106].
- 454 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [88].
- 455 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [89].
- 456 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [94].
- 457 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [95]–[96].
- 458 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [93].
- 459 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [98]–[99].
- 460 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [101].
- 461 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [83].
- 462 Transcript of R Cummings, Case Study 30, 18 August 2015, C8955:14–21.
- 463 Transcript of R Cummings, Case Study 30, 18 August 2015, C8955:10–21.
- 464 Transcript of T Verberne, Case Study 30, 18 August 2015, C8980:24–8; See Exhibit 30-0004, Annexure RJC-15, DHS.3002.082.0009\_E.
- 465 Submissions of T Verberne, SUBM.1030.020.0001 at [11].
- 466 Further Submissions of R Cummings, SUBMS.1030.015.0005 at [4].
- 467 Transcript of T Verberne, Case Study 30, 18 August 2015, C8986:3–9.
- 468 Transcript of T Verberne, Case Study 30, 18 August 2015, C8993:18–25.

- 469 Transcript of T Verberne, Case Study 30, 18 August 2015, C8993:45–C8994:7.  
 470 Transcript of T Verberne, Case Study 30, 18 August 2015, C8993:27–9.  
 471 Transcript of T Verberne, Case Study 30, 18 August 2015, C9002:18–27.  
 472 Transcript of BHE, Case Study 30, 19 August 2015, C9120:13–C9121:20; Transcript of BDF, Case Study 30, 21 August 2015, C9351:27–C9353:40; Transcript of Katherine X, Case Study 30, 19 August 2015, C9161:21–C9162:8.  
 473 Transcript of E Slack, Case Study 30, 26 August 2015, C9595:11–26.  
 474 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0084.  
 475 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0084.  
 476 Transcript of E Slack, Case Study 30, 26 August 2015, C9595:40–C9596:6.  
 477 Transcript of L Owen, Case Study 30, 25 August 2015, C9514:28–32; Transcript of E Slack, Case Study 30, 26 August 2015, C9699:38–42.  
 478 Transcript of E Slack, Case Study 30, 26 August 2015, C9598:18–30.  
 479 Transcript of BHE, Case Study 30, 19 August 2015, C9121:3–10.  
 480 Transcript of Katherine X, Case Study 30, 20 August 2015, C9163:18–21.  
 481 Transcript of Winnie Girls documentary, Case Study 30, 24 August 2015, C9376:7–14.  
 482 Transcript of E Slack, Case Study 30, 26 August 2015, C9629:47–C9630:3, C9630:26–43, C9631:4–10, C9666:37–43, C9671:1–10, C9699:8–22.  
 483 Transcript of E Slack, Case Study 30, 26 August 2015, C9699:16–31.  
 484 Transcript of BHE, Case Study 30, 24 August 2015, C9121:12–20.  
 485 See Exhibit 30-0029, Case Study 30, TEN.0027.001.0001 at 0002; Transcript of E Slack, Case Study 30, 26 August 2015, C9630:5–13, C9631:31–7, C9672:8–37, C9674:16–29; Transcript of M Minister, Case Study 30, 24 August 2015, C9445:33–42, C9446:10–13, C9447:14–20; Transcript of Katherine X, Case Study 30, 20 August 2015, C9162:10–25; Exhibit 30-0017, Case Study 30, Annexure KX-7, DHS.3002.323.0111\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-29, DHS.3002.323.0045\_E\_R.  
 486 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [34], [39]–[41]; Exhibit 30-0014, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [30], [33], [37], [39]; Exhibit 30-0016, ‘Statement of K Hodkinson’, Case Study 30, STAT.0614.001.0001\_R at [40], [45]–[46]; Exhibit 30-0022, ‘Statement of BDF’, STAT.0616.001.0001\_M\_R at [35]–[36], [40], [44]–[45].  
 487 Transcript of E Slack, Case Study 30, 26 August 2015, C9701:9–14.  
 488 Exhibit 30-0001, ‘Statement of N Latham’, Case Study 30, STAT.0611.001.0001\_R at [58]–[60].  
 489 Exhibit 30-0001, ‘Statement of N Latham’, Case Study 30, STAT.0611.001.0001\_R at [64].  
 490 Exhibit 30-0001, ‘Statement of N Latham’, Case Study 30, STAT.0611.001.0001\_R at [65]–[67].  
 491 Exhibit 30-0002, ‘Statement of J Marijancevic’, Case Study 30, STAT.0610.001.0001\_R at [77]–[78].  
 492 Exhibit 30-0002, ‘Statement of J Marijancevic’, Case Study 30, STAT.0610.001.0001\_R at [79]–[80].  
 493 Exhibit 30-0042, ‘Statement of BDD’, Case Study 30, STAT.0620.001.0001\_M\_R at [30], [33], [53]–[55].  
 494 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [48].  
 495 Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [47].  
 496 Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [50].  
 497 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0032; Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0121; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0103–0104.  
 498 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0032; Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0120–0121; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0102–0103.  
 499 Exhibit 30-0012, ‘Statement of A Cadd’, Case Study 30, STAT.0637.001.0001\_R at [45(b)].  
 500 Exhibit 30-0011, Case Study 30, DHS.3004.003.0001 at 0032; Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0120; see also Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0101.  
 501 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0121–0122; Exhibit 30-0011, Case Study 30, DHS.3127.002.0019 at 0105.  
 502 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0178.  
 503 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [22]; Exhibit 30-0011, Case Study 30, VPOL.3027.001 .0023; Exhibit 30-0011, Case Study 30, VPOL.3027.001 .0029; Exhibit 30-0011, Case Study 30, VPOL. 3027.001 .0040.  
 504 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [21]–[22].  
 505 Transcript of S Fontana, Case Study 30, 27 August 2015, C9835:17–C9836:10.

506 Transcript of A Cadd, Case Study 30, 19 August 2015, C9050:12–28.  
507 Transcript of S Fontana, Case Study 30, 27 August 2015, C9874:6–21.  
508 Transcript of S Fontana, Case Study 30, 27 August 2015, C9826:44–C9827:19; Exhibit 30-0041, ‘Statement of  
S Fontana’, Case Study 30, STAT.0623.001.0001 at [18].  
509 Exhibit 20-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [18]; Transcript of S  
Fontana, Case Study 30, 27 August 2015, C9827:41–3.  
510 Transcript of S Fontana, Case Study 30, 27 August 2015, C9827:29–39.  
511 Transcript of S Fontana, Case Study 30, 27 August 2015, C9830:35–C9831:22.  
512 Transcript of S Fontana, Case Study 30, 27 August 2015, C9830:35–C9831:18.  
513 Transcript of S Fontana, Case Study 30, 27 August 2015, C9831:34–C9833:19.  
514 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [57].  
515 Transcript of S Fontana, Case Study 30, 27 August 2015, C9830:11–33.  
516 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [25].  
517 Transcript of S Fontana, Case Study 30, 27 August 2015, C9850:46–C9851:18.  
518 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [55].  
519 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [76]–[77].  
520 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [78].  
521 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [80]–[82].  
522 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [27.1], [28]–[29].  
523 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [59]–[60].  
524 Exhibit 30-0041, ‘Statement of S Fontana’, Case Study 30, STAT.0623.001.0001 at [60].  
525 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [41], [83].  
526 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [25]–[34].  
527 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [39].  
528 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [50], [52].  
529 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [83].  
530 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [102].  
531 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [105].  
532 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [106]–[111].  
533 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [122]–[123].  
534 Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [5]–[6]; Transcript of J  
Mitchell, Case Study 30, 20 August 2015, C9210:9–19.  
535 Exhibit 30-0020, ‘Statement of M Groome’, Case Study 30, STAT.0628.001.0001\_R at 0002\_R, 0004\_R.  
536 Transcript of M Groome, Case Study 30, 21 August 2015, C9251:46–C9252:41, C9259:38–C9260:16; Exhibit  
30-0021, Case Study 30, EXH.030.021.0001\_R.  
537 Transcript of M Groome, Case Study 30, 21 August 2015, C9251: 46–C9253:26, C9259:47–C9260:16,  
C9295:15–34.  
538 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9178:37–42; Transcript of M Minister, Case Study  
30, 24 August 2015, C9426:44–C9427:3; Exhibit 30-0034, ‘Statement of E Slack’, STAT.0630.001.0001\_R at [40].  
539 Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [13].  
540 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [13].  
541 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [16].  
542 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [19].  
543 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [20].  
544 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [25]–[34].  
545 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [33].  
546 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [35].  
547 Exhibit 30-0017, Case Study 30, Annexure KX-4, DHS.3002.323.0146\_E\_R; Exhibit 30-0017, ‘Statement of  
Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [39].  
548 Exhibit 30-0017, Case Study 30, Annexure KX-5, DHS.3002.323.0144\_E\_R at 0144\_E.  
549 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [41]–[42].  
550 Transcript of S Fontana, Case Study 30, 27 August 2015, C9859:13–C9860:4.  
551 Transcript of S Fontana, Case Study 30, 27 August 2015, C9859:38–C9860:4.  
552 Transcript of S Fontana, Case Study 30, 27 August 2015, C9877:38–C9878:32; Exhibit 30-0011, Case Study  
30, VPOL.3029.002.0279\_E at 0295\_E.

- 553 Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.0001\_R\_M at [49]–[50], [52]; Transcript of Katherine X, Case Study 30, 20 August 2015, C9159:21–34.
- 554 Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.0001\_R\_M at [48].
- 555 Transcript of Katherine X, Case Study 30, 20 August 2015, C9162:7–9, C9163:33–5.
- 556 Transcript of Katherine X, Case Study 30, 20 August 2016, C9163:36–43.
- 557 Exhibit 30-0017, Case Study 30, Annexure KX-7, DHS.3002.323.0111\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-8, DHS.3002.323.0107\_E; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9216:4-8.
- 558 Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.0001\_R\_M at [53]–[54], [57]–[58], [60]–[61].
- 559 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0203.
- 560 Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.0001\_R\_M at [53].
- 561 Exhibit 30-0017, Case Study 30, Annexure KX-9, DHS.3002.323.0108\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 11, DHS.3002.323.0124\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 13, DHS.3002.323.0116\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 14, DHS.3146.002.0306; Exhibit 30-0017, Case Study 30, Annexure KX 22, DHS.3002.323.0097\_E\_R.
- 562 Exhibit 30-0017, Case Study 30, Annexure KX-9, DHS.3002.323.0108\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-11, DHS.3002.323.0124\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-13, DHS.3002.323.0116\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-14, DHS.3146.002.0306\_R; Exhibit 30-0017, Case Study 30, Annexure KX-22, DHS.3002.323.0097\_E\_R.
- 563 Exhibit 30-0017, Case Study 30, Annexure KX-9, DHS.3002.323.0108\_E.
- 564 Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.0001\_R\_M at [56]; Exhibit 30-0011, Case Study 30, DHS.3026.0004.0150.
- 565 Exhibit 30-0017, Case Study 30, Annexure KX-10, DHS.3002.323.0276\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-16, DHS.3002.323.0245\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-18, DHS.3002.323.0287\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-19, DHS.3002.323.0274\_E\_R.
- 566 Exhibit 30-0017, Case Study 30, Annexure KX-20, DHS.3002.323.0153\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-21, DHS.3002.323.0252\_E\_R.
- 567 Exhibit 30-0017, Case Study 30, Annexure KX-9, DHS.3002.323.0108\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 11, DHS.3002.323.0124\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 13, DHS.3002.323.0116\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX 14, DHS.3146.002.0306; Exhibit 30-0017, Case Study 30, Annexure KX 22, DHS.3002.323.0097\_E\_R.
- 568 Transcript of M Groome, Case Study 30, 21 August 2015, C9251:46–C9252:41; Exhibit 30-0021, Case Study 30, EXH.030.021.0001\_R; Exhibit 30-0021, Case Study 30, EXH.030.021.0001\_R.
- 569 Transcript of M Groome, Case Study 30, 21 August 2015, C9259:38–C9260:16.
- 570 Transcript of M Groome, Case Study 30, 21 August 2015, C9251:46–C9252:41, C9259:47–C9260:16, C9295:15–34.
- 571 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9184:43–9185:16; Transcript of M Groome, Case Study 30, 21 August 2015, C9283:21–45; Transcript of M Groome, Case Study 30, 21 August 2015, C9262:12–19; Submissions of B Fitzgerald, Case Study 30, SUBM.1030.005.0003 at [7]; Submissions of J Mitchell, Case Study 30, SUBM.1030.007.0001 at [6]–[7].
- 572 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9182:30–44, C9183:15–19; Exhibit 30-0019, 'Statement of J Mitchell', Case Study 30, STAT.0640.001.0001\_R at [16]; Transcript of M Minister, Case Study 30, 24 August 2015, C9427:1–20; Exhibit 30-0017, Case Study 30, Annexure KX-5, DHS.3002.323.0144\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-6, DHS.3002.326.0004; Exhibit 30-0017, Case Study 30, Annexure KX-7, DHS.3002.323.0111\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-8, DHS.3002.323.0107\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-9, DHS.3002.323.0108\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-10, DHS.3002.323.0276\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-11, DHS.3002.323.0124\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-18, DHS.3002.323.0287\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-19, DHS.3002.323.0274\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-20, DHS.3002.323.0253\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-21, DHS.3002.323.0254\_E\_R.
- 573 Exhibit 30-0019, 'Statement of J Mitchell', Case Study 30, STAT.0640.001.0001\_R at [24]; Transcript of M Groome, Case Study 30, 21 August 2015, C9278:5–19, C9292:11–23; Transcript of M Minister, Case Study 30, 24 August 2015, C9439:23–36; Transcript of S Fontana, Case Study 30, 27 August 2015, C9841:35–43.
- 574 Transcript of M Minister, Case Study 30, 24 August 2015, C9452:21–31, C9480:40–3.

- 575 *Crimes Act 1891* (Vic) s 8.  
576 *Crimes Act 1958* (Vic) s 52.  
577 *Crimes Act 1958* (Vic) s 44.  
578 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9186:26–C9187:2; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9231:42–C9232:18; Transcript of M Groome, Case Study 30, 21 August 2015, C9262:22–33.  
579 Transcript of M Groome, Case Study 30, 21 August 2015, C9276:41–C9277:6; Transcript of M Minister, Case Study 30, 24 August 2015, C9432:7–16, C9452:21–31, C9480:40–3, C9483:26–33.  
580 Transcript of M Groome, Case Study 30, 21 August 2015, C9289:28–35.  
581 Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [24]; Transcript of M Groome, Case Study 30, C9289:28-35; Transcript of M Minister, Case Study 30, C9432:7-16.  
582 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [89].  
583 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [99].  
584 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9190:31–9.  
585 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9173:24–31; Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [4]–[5], [11]; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9213:8–13; Transcript of M Groome, Case Study 30, 21 August 2015, C9250:34–44.  
586 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9184:22–33; Exhibit 30-0018, ‘Statement of B Fitzgerald’, Case Study 30, STAT.0621.001.0001\_R at [12]; Transcript of M Groome, Case Study 30, 21 August 2015, C9255:18–C9256:12, C9262:6–10.  
587 Transcript of M Groome, Case Study 30, 21 August 2015, C9253:41–C9254:1, C9322.29–33.  
588 Transcript of M Groome, Case Study 30, 21 August 2015, C9261:33–C9262:44.  
589 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9211:20–34, C9227:39–44, C9240:35–43.  
590 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9227:39–44, C9240:35–43.  
591 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9180:3–13; Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [7], [9]; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9211:11–18, C9212:44–7.  
592 Exhibit 30-002, ‘Statement of M Groome’, Case Study 30, STAT.0628.001.0001\_R at 0005\_R.  
593 Transcript of M Groome, Case Study 30, 21 August 2015, C9256:14–16.  
594 Transcript of M Groome, Case Study 30, 21 August 2015, C9256:40–3.  
595 Transcript of M Groome, Case Study 30, 21 August 2015, C9267:41–C9268:3.  
596 Transcript of M Groome, Case Study 30, 21 August 2015, C9258:47–9259:9, C9262:35–40.  
597 Submissions of J Mitchell, Case Study 30, SUBM.1030.007.0001 at [14], [16]–[17].  
598 Submissions of B Fitzgerald, Case Study 30, SUBM.1030.005.0001 at [6]–[7].  
599 Submissions of B Fitzgerald, Case Study 30, SUBM.1030.005.0001 at [8].  
600 Further Submissions of the State of Victoria, Case Study 30, SUBM.1030.017.0008 at [4]; See Exhibit 30-0047, Case Study 30, EXH.030.047.0001 at 0007, 0009–0012.  
601 Further Submissions of the State of Victoria, Case Study 30, SUBM.1030.017.0008 at [4].  
602 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [62]–[65].  
603 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [66]–[67].  
604 Exhibit 30-0017, Case Study 30, Annexure KX-18, DHS.3002.323.0287\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-17, DHS.3002.323.0104\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-15, DHS.3002.323.0275\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-16, DHS.3002.323.0245\_E\_R.  
605 Exhibit 30-0017, Case Study 30, Annexure KX-18, DHS.3002.323.0287\_E\_R; see also Exhibit 30-0017, Case Study 30, Annexure KX-17, DHS.3002.323.0104\_E\_R.  
606 Exhibit 30-0017, Case Study 30, Annexure KX-16, DHS.3002.323.0245\_E\_R.  
607 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [68].  
608 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [69]–[71].  
609 Exhibit 30-0017, Case Study 30, Annexure KX-16, DHS.3002.323.0245\_E\_R at [8].  
610 Exhibit 30-0017, Case Study 30, Annexure KX-19, DHS.3002.323.0274\_E\_R; Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [72].  
611 Exhibit 30-0011, Case Study 30, DHS.3004.001.0078 at 0106.  
612 Transcript of L Owen, Case Study 30, 25 August 2015, C9504:29–41; Transcript of E Slack, Case Study 30, 26 August 2015, C9651:9–21.  
613 Exhibit 30-0017, Case Study 30, Annexure KX-15, DHS.3002.323.0275\_E\_R.

- 614 Transcript of M Minister, Case Study 30, 24 August 2015, C9383:39–C9384:11.
- 615 Transcript of M Minister, Case Study 30, 24 August 2015, C9386:35–C9387:35; see also Exhibit 30-0011, Case Study 30, DHS.3128.003.0012 at 0017.
- 616 Transcript of M Minister, Case Study 30, 24 August 2015, C9427:1–20; Exhibit 30-0017, Case Study 30, Annexure KX-10, DHS.3002.323.0276\_E\_R.
- 617 Transcript of M Minister, Case Study 30, 24 August 2015, C9428:47–C9429:8.
- 618 Transcript of M Minister, Case Study 30, 24 August 2015, C9441:45–C9442:10.
- 619 Transcript of M Groome, Case Study 30, 21 August 2015, C9300:1–37.
- 620 Transcript of M Groome, Case Study 30, 21 August 2015, C9305:9–19.
- 621 Transcript of M Minister, Case Study 30, 24 August 2015, C9438:39–42, C9448:37–46, C9449:38–C9450:19.
- 622 Submissions of M Minister, Case Study 30, SUBM.1030.006.0001 at [47].
- 623 Transcript of M Minister, Case Study 30, 24 August 2015, C9429:41–C9430:10.
- 624 Transcript of M Minister, Case Study 30, 24 August 2015, C9428:14–22; Transcript of M Groome, Case Study 30, 21 August 2015, C9274:18–31.
- 625 Transcript of M Groome, Case Study 30, 21 August 2015, C9274:33–C9275:7.
- 626 Transcript of E Slack, Case Study 30, 26 August 2015, C9653:20–5.
- 627 Transcript of E Slack, Case Study 30, 26 August 2015, C9649:10–14.
- 628 Transcript of E Slack, Case Study 30, 26 August 2015, C9653:27–45.
- 629 Transcript of E Slack, Case Study 30, 26 August 2015, C9649:47–C9650:2.
- 630 Transcript of E Slack, Case Study 30, 26 August 2015, C9650:14–29, C9689:14–24.
- 631 Transcript of E Slack, Case Study 30, 26 August 2015, C9682:10–15.
- 632 Transcript of E Slack, Case Study 30, 26 August 2015, C9652:20–37, C9653:27–38.
- 633 Transcript of E Slack, Case Study 30, 26 August 2015, C9650:4–12.
- 634 Transcript of E Slack, Case Study 30, 26 August 2015, C9661:41–4.
- 635 Transcript of M Minister, Case Study 30, 24 August 2015, C9471:12–21.
- 636 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [51].
- 637 Transcript of M Groome, Case Study 30, 21 August 2015, C9270:41–C9271:27.
- 638 Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001 at [24].
- 639 Transcript of M Minister, Case Study 30, 24 August 2015, C9429:19–23, C9430:26–30.
- 640 Transcript of M Minister, Case Study 30, 24 August 2015, C9482:16–21.
- 641 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [47].
- 642 Exhibit 30-0017, Case Study 30, Annexure KX-6, DHS.3002.326.0004.
- 643 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.00001\_R\_M at [96].
- 644 Exhibit 30-0017, Case Study 30, Annexure KX-30, DHS.3002.323.0082\_E\_R at 0083\_R.
- 645 Transcript of Winnie Girls documentary, Case Study 30, 24 August 2015, C9374:24–9.
- 646 Exhibit 30-0011, Case Study 30, DHS.3002.381.0008 at 0181–0182.
- 647 Transcript of M Minister, Case Study 30, 24 August 2015, C9396:43–7; Transcript of E Slack, Case Study 30, 26 August 2015, C9609:23–31.
- 648 Exhibit 30-0034, ‘Statement of E Slack’, Case Study 30, STAT.0630.001.0001\_R at [45]; Exhibit 30-0034, ‘Statement of E Slack’, Annexure L, Case Study 30, STAT.0630.001.0066; Exhibit 30-0034, ‘Statement of E Slack’, Annexure L, Case Study 30, STAT.0630.001.0067; Transcript of E Slack, Case Study 30, 26 August 2015, C9605:41–C9606:5.
- 649 Transcript of E Slack, Case Study 30, 26 August 2015, C9603:36–44; Transcript of L Owen, Case Study 30, 25 August 2015, C9518:6–13; Transcript of M Minister, Case Study 30, 24 August 2015, C9397:2–11.
- 650 Exhibit 30-0011, Case Study 30, DHS.3002.381.0008 at 0181–0182.
- 651 Transcript of Winnie Girls documentary, Case Study 30, 24 August 2015, C9375:3–18.
- 652 Transcript of Winnie Girls documentary, Case Study 30, 24 August 2015, C9375:5–8.
- 653 Transcript of M Minister, Case Study 30, 24 August 2015, C9397:34–6.
- 654 Transcript of M Minister, Case Study 30, 24 August 2015, C9399:31–C9340:8.
- 655 Transcript of M Minister, Case Study 30, 24 August 2015, C9400:3–4.
- 656 Exhibit 30-0032, Case Study 30, DHS.3002.326.0008\_R.
- 657 Transcript of E Slack, Case Study 30, 26 August 2015, C9698:47–9699:6.
- 658 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [79].
- 659 Exhibit 30-0017, Case Study 30, Annexure KX-24, DHS.3002.323.0068\_E\_R at [15].
- 660 Exhibit 30-0017, Case Study 30, Annexure KX-24, DHS.3002.323.0068\_E\_R at [13].

- 661 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9206:8–13.
- 662 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9206:44–C9027:6.
- 663 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [83].
- 664 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [92].
- 665 Transcript of M Minister, Case Study 30, 24 August 2015, C9443:18–27.
- 666 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9229:43–C9280:18; Transcript of M Groome, Case Study 30, 21 August 2015, C9285:10–15.
- 667 Exhibit 30-0017, Case Study 30, Annexure KX-25, DHS.3002.326.0017.
- 668 Transcript of M Groome, Case Study 30, 21 August 2015, C9320:29–C9321:8.
- 669 Transcript of B Fitzgerald, Case Study 30, 20 August 2015, C9180:31–9, C9193:41–C9194:5, C9201:39–C9202:1.
- 670 Transcript of M Minister, Case Study 30, 24 August 2015, C9443:29–33; Exhibit 30-0017, Case Study 30, Annexure KX-24, DHS.3002.323.0068\_E\_R.
- 671 Exhibit 30-0017, Case Study 30, Annexure KX-28, DHS.3002.323.0088\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-29, DHS.3002.323.0045\_E\_R.
- 672 Exhibit 30-0017, Case Study 30, Annexure KX-27, DHS.3002.323.0249\_E\_R.
- 673 Transcript of M Groome, Case Study 30, 21 August 2015, C9288:29–35, C9313:13–35.
- 674 Submissions of Katherine X, Case Study 30, SUBM.1030.016.0001 at [85]; Further Submissions of Katherine X, Case Study 30, SUBM.1030.016.0018 at [12].
- 675 Exhibit 30-0017, Case Study 30, Annexure KX-26, DHS.3146.002.0291\_R; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9238:29–C9239:9.
- 676 Transcript of M Minister, Case Study 30, 24 August 2015, C9440:23–35.
- 677 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0015\_R\_M at [86]–[87].
- 678 Exhibit 30-0019, ‘Statement of J Mitchell’, Case Study 30, STAT.0640.001.0001\_R at [25].
- 679 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9223:4–7,
- 680 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9245:25–39.
- 681 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9224:32–4; Transcript of M Groome, Case Study 30, 21 August 2015, C9288:41–C9289:9.
- 682 Transcript of M Groome, Case Study 30, 21 August 2015, C9317:4–13; Transcript of J Mitchell, Case Study 30, 20 August 2015, C9234:35–8, C9239:39–C9240:10.
- 683 Transcript of J Mitchell, Case Study 30, 20 August 2015, C9225:9–C9226:16.
- 684 Exhibit 30-0017, Case Study 30, Annexure KX-28, DHS.3002.323.0088\_E\_R; Exhibit 30-0017, Case Study 30, Annexure KX-29, DHS.3002.323.0045\_E\_R.
- 685 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [101].
- 686 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [113].
- 687 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [114].
- 688 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [114].
- 689 Transcript of Katherine X, Case Study 30, 20 August 2015, C9164:13–18.
- 690 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [114].
- 691 Transcript of S Fontana, Case Study 30, 27 August 2015, C9846:1–15.
- 692 Transcript of S Fontana, Case Study 30, 27 August 2015, C9846:39–C9847:4.
- 693 Transcript of S Fontana, Case Study 30, 27 August 2015, C9846:17–26.
- 694 Transcript of S Fontana, Case Study 30, 27 August 2015, C9846:32–7.
- 695 Transcript of S Fontana, Case Study 30, 27 August 2015, C9847:6–16.
- 696 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [116].
- 697 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [119].
- 698 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [121]–[122].
- 699 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [123].
- 700 Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [116]–[127].
- 701 Transcript of V Philip, Case Study 30, 28 August 2015, C9884:23–C9885:44.
- 702 Transcript of V Philip, Case Study 30, 28 August 2015, C9885:11–14.
- 703 Exhibit 30.0046, ‘Third statement of V Philip’, Case Study 30, STAT.0626.004.0001 at [8].
- 704 Transcript of V Philip, Case Study 30, 28 August 2015, C9894:43–C9895:5.
- 705 Exhibit 30.0046, ‘Third statement of V Philip’, Case Study 30, STAT.0626.005.0001 at [210]–[211].
- 706 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [59]–[62].

- 707 Transcript of V Philip, Case Study 30, 28 August 2015, C9907:35–C9908:20.
- 708 Transcript of V Philip, Case Study 30, 28 August 2015, C9890:27–C9891:2; Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [72].
- 709 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [73].
- 710 Transcript of V Philip, Case Study 30, 28 August 2015, C9899:2–28.
- 711 Transcript of V Philip, Case Study 30, 28 August 2015, C9909:14–33.
- 712 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [58].
- 713 Exhibit 30-0046, ‘Third statement of V Philip’, Case Study 30, STAT.0626.005.0001 at [91].
- 714 Transcript of V Philip, Case Study 30, 28 August 2015, C9892:39–44.
- 715 Transcript of V Philip, Case Study 30, 28 August 2015, C9898:24–47.
- 716 Transcript of V Philip Case Study 30, 28 August 2015, C9895:7–25.
- 717 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [107]–[108].
- 718 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [103]–[104].
- 719 Exhibit 30-0047, EXH.030.047.0001 at 0010-0012; Transcript of V Philip, Case Study 30, 28 August 2015, C9957:36–C9958:7.
- 720 Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [141]–[144]; Transcript of V Philip, Case Study 30, 28 August 2015, C9891:4–22.
- 721 Transcript of V Philip, Case Study 30, 28 August 2015, C9891:24–47; Exhibit 30-0046, ‘Amended first statement of V Philip’, Case Study 30, STAT.0626.003.0001 at [134]–[139].
- 722 Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [99]; Transcript of BDB, Case Study 30, 18 August 2015, C8924:30–5.
- 723 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9774:26–37.
- 724 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9769:7–14.
- 725 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9769:40–6.
- 726 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9769:34–8.
- 727 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9769:40–6.
- 728 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9770:1–5.
- 729 *Freedom of Information Act* 1982 (Cth) s 21.
- 730 Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [61]; Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [134]; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [102], [107]; Transcript of BDA, Case Study 30, 26 August 2015, C9724:32–42, C9725:5–11.
- 731 Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [61].
- 732 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9773:36–C9774:5.
- 733 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9773:36–47, C9813:30–C9814:12.
- 734 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9774:26–46.
- 735 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9774:26–46, C9790:15–28.
- 736 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9790:35–46.
- 737 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9775:1–8.
- 738 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [139]; Exhibit 30-0002, ‘Statement of J Marijancevic’, Case Study 30, STAT.0610.001.0001 at [105]; Exhibit 30-0017, ‘Statement of Katherine X’, Case Study 30, STAT.0615.001.0001\_R\_M at [132]–[133]; Exhibit 30-0014, ‘Statement of BDC’, Case Study 30, STAT.0607.001.0001\_M\_R at [93]; Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [64]; Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R at [60]; Exhibit 30-0022, ‘Statement of BDF’, Case Study 30, STAT.0616.001.0001\_M\_R at [86]; Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [86]; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [104]–[105]; Exhibit 30-0044, ‘Statement of BHU’, Case Study 30, STAT.0653.001.0001\_M\_R at [61].
- 739 Exhibit 30-0004, ‘Statement of R Cummings’, Case Study 30, STAT.0608.001.0001\_R\_M at [139]; Exhibit 30-0002, ‘Statement of J Marijancevic’, Case Study 30, STAT.0610.001.0001 at [105]; Exhibit 30-0015, ‘Statement of BHE’, Case Study 30, STAT.0613.001.0001\_M\_R at [64]; Exhibit 30-0036, ‘Statement of BDA’, Case Study 30, STAT.0617.002.0001\_M\_R at [104]–[105].
- 740 Exhibit 30-0016, ‘Statement of K Hodgkinson’, Case Study 30, STAT.0614.001.0001\_R [60]; Exhibit 30-0023, ‘Statement of G Short’, Case Study 30, STAT.0647.001.0001\_M\_R at [86].



- 741 Exhibit 30-0002, 'Statement of J Marijancevic', Case Study 30, STAT.0610.001.0001\_R at [105]–[106]; Exhibit 30-0014, 'Statement of BDC', Case Study 30, STAT.0607.001.0001\_M\_R at [93]; Exhibit 30-0017, 'Statement of Katherine X', Case Study 30, STAT.0615.001.001\_R\_M at [133].
- 742 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9779:5–16.
- 743 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9812:13–37, C9779:23–37; Submissions of State of Victoria, Case Study 30, SUBM.1030.017.0001 at [7].
- 744 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9779:44–C9780:2, C9780:4–14.
- 745 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9812:39–C9813:7, C9781:11–27, C9786:3–10.
- 746 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9780:16–31.
- 747 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9803:12–28.
- 748 Submissions of State of Victoria, Case Study 30, SUBM.1030.017.0001 at [8]–[10].
- 749 Transcript of S Hodgkinson, Case Study 30, 27 August 2015, C9781:37–C9782:11; Exhibit 30-0011, Case Study 30, DHS.3148.001.0040 at 0040.
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- 765 Exhibit 30-0015, 'Statement of BHE', Case Study 30, STAT.0613.001.0001\_M\_R at [65]–[66]; Exhibit 30-0022, 'Statement of BDF', Case Study 30, STAT.0616.001.0001\_M\_R at [83]–[84]; Exhibit 30-0003, 'Statement of BDB', Case Study 30, STAT.0609.001.0001\_R at [87], [93]; Exhibit 30-0036, 'Statement of BDA', Case Study 30, STAT.0617.002.0001\_M\_R at [106].
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ISBN: 978-1-925289-58-9  
Published April 2016