EXECUTIVE SUMMARY

INTRODUCTION

In August 1998 the Minister for Families, Youth and Community Care established a Commission of Inquiry to examine whether there had been any abuse, mistreatment or neglect of children in Queensland institutions. The Commission was given a tight timeframe to report to the Government, initially to be 1 March 1999 and extended to 31 May 1999.

This is no ordinary report. This was no ordinary Inquiry. For the Commissioners and staff of the Inquiry, the experience has been deeply moving and deeply disquieting. We have heard repeated reports of physical and sexual abuse in government and non-government institutions over decades, which have resulted in irreparable damage to the lives of many Queenslanders. Why did this happen? How can anyone possibly repair the damage done? How can we as a society ensure that such violations never again occur to children whose care we have entrusted to the State?

The Commission has taken a child- centred approach to its deliberations. Children are our most precious resource. They are our future. Their experience as children will determine what kind of adults they become and what kind of society there will be. One act of abuse or mistreatment towards a child is one act too many. Repeated acts of abuse that have gone unrecognised and unaddressed are inexcusable. Although there have been many reasons presented to the Commission as to how and why the abuses took place, none excuse the abuse, nor do they excuse the failure of those in authority in government, churches and society in general to effectively deal with complaints of abuse. We have failed these most disadvantaged and powerless children in the past. It is vital that we do not continue to do so.

The challenge placed before the Commission has been daunting. It encompassed the period from 1911 to the present day, and more than 150 orphanages and detention centres. The paucity of written records and archival material, the small proportion of ex-residents of institutions who came forward, and the understandable reluctance of current residents to speak freely of their experiences in institutions have made our task more difficult.

Over 300 people provided information to the Commission and shared their often tragic life experiences. Many of them showed great tenacity and survival after years of hiding their deep secrets, with no one to tell. For individuals, their childhood experiences, the separation from their parents and siblings and their placement in orphanages and detention centres have deeply scarred them and had an immeasurable impact on the rest of their lives. These experiences continue to affect victims and families to this day. We heard stories of children feeling worthless, vulnerable, stigmatised, unloved and being denied opportunities, and adult lives filled with poor personal relationships, broken marriages, suicide attempts, uncertainty and insecurity.

A number of witnesses to the Inquiry have described severe and prolonged trauma. In some cases, up to fifty years have elapsed between the abuse and the disclosure to the Inquiry. We recognise that this raises questions about the accuracy of these memories. The issue was also raised by witnesses who feared that they would not be believed. After reviewing the literature, we conclude that there is no completely accurate way of determining the validity of abuse reports without corroboration. There are many factors that can influence the accuracy of memories. We have been guided by the substantial literature that recognises delayed recall and dissociation but caution the reader that the detail of witnesses' memories cannot be automatically interpreted as a literal, historical reality. In many cases, we have heard similar accounts corroborated by several witnesses, and archival material has provided substantial corroboration of the broad thrust, if not the detail, of witnesses' evidence.

We recognise that for some victims it is the process of sharing their experience that offers an opportunity for progressive self-healing, and above all it offers the chance to be heard, believed and acknowledged. We acknowledge the courage and the inner strength required of the many victims who appeared before the Inquiry.

We have recognised the need to place historical matters within the context of the prevailing social attitudes and economic circumstances, but the abuses disclosed went far beyond the prevailing acceptable limits. We also understand the often extreme constraints placed on carers, who may have been inadequately prepared for their task and who had far too many children in their care. In some cases, those directly responsible for the children may also have been vulnerable as a result of limited quality relationships and social support systems. We heard that relationships among staff in some institutions were discouraged and they were permitted limited contact with the outside community. Sometimes, the carers also were drawn from the same institutions.

We believe that it is important to place on the public record that few of the children historically placed in orphanages were, in fact, orphans. Most were either removed from their families by the State, or placed in orphanages by their parents, who for various reasons (such as the death or illness of one parent) were unable to look after them. In the case of indigenous children, this occurred simply because of the colour of their skin. Very few of the British child migrants (erroneously referred to at the time as 'war orphans') were orphans.

Another disturbing matter for the public record is that many children who have been incarcerated in the State's reformatories, detention centres and similar institutions over the years should never have been incarcerated at all. Some boys were sent there simply because they reached the age of 14 years and could no longer stay in an orphanage; girls were often placed there for being in 'moral danger', which generally referred to being active sexually; others were placed there for minor offences such as truancy or running away. These children then associated with children who were convicted of criminal offences, were treated like criminals, were labelled as criminals, and were treated far more harshly than their behaviour ever warranted. Little wonder that many of these children subsequently fell into criminal activities and have bitterly resented their unjust incarceration.

While we have been deeply moved and indeed disturbed by the events of the past, we are conscious that there remain approximately 300 Queensland children in residential institutions and detention centres today. Their safety and protection is a critical concern. We cannot rebuild their childhood for past survivors, but we do have a responsibility to ensure that children in care today suffer no harm while in that care. Understandably, the Commission heard from few children currently in care in institutions—it is unlikely that such children would have the confidence to come forward. As a result, we have taken a number of steps to seek the views of children in institutions today, in both residential and detention settings, and to assess their risk of abuse in those institutions. Sadly, our findings indicate that there remain some risk situations, where children may still be exposed to abuse and mistreatment. It is vital that these be addressed.

We acknowledge that we have seen only a small proportion of children who were in institutions and that some children may have had pleasant or at least neutral experiences in those institutions. Indeed the Commission has heard from a small number of witnesses from orphanages who came forward to express strong support for the institutions where they were resident. However, we have taken the clear view that one child abused while in the care of the government is one child too many.

The process

There have been two major thrusts of the Inquiry: first, an investigation into institutional abuse that has occurred in the past, based on oral and written evidence and from archival research; and second, a review of the current systems, which included reviews of legislation, policy and practice, evidence from public and private hearings, and inspections of facilities.

We adopted a broad range of strategies to inform likely stakeholders and the general public about the Inquiry. The Inquiry consulted with stakeholder groups, invited individuals who had resided or worked in institutions within the Terms of Reference to come forward, and invited submissions from other interested individuals and organisations.

We were conscious of the constraints faced by indigenous people in coming forward. This was evidenced by the limited submissions received from indigenous people, despite their disproportionately high representation in many institutions covered by the Terms of Reference. In response to this we took a range of steps to increase the likelihood of information being obtained from indigenous people.

Predominantly the hearings have been conducted in private. This has been for two main reasons. First, the sensitive and private nature of the evidence given led many witnesses to request full confidentiality. Second, during the period of the Inquiry there was a substantial amount of civil litigation and outstanding criminal proceedings in relation to the subject matter of some of the evidence. Public hearings would have prejudiced these proceedings, and persons named adversely in public hearings can be unjustifiably prejudiced if evidence is taken before an opportunity to respond has been given.

In addition to hearings and interviews, the Inquiry received evidence in the form of written submissions from individuals and organisations. Expert evidence was also received through written submissions and public hearings.

To ensure full coverage of the matters within the Terms of Reference, we commissioned a number of independent experts to examine a broad range of areas relevant to the Inquiry. The research unit of the Inquiry carried out literature reviews to provide context, and to inform the Inquiry about current developments in the field of institutional child abuse. These studies were guided by current literature, and were supported by a number of submissions to the Inquiry from academic and professional experts. In addition, we carried out a systematic review of archival evidence.

The report

The report has been designed to provide readers not only with our findings but also information on the very complex subject of child abuse in institutions. As our brief has covered a period of several decades, we have also sought to examine the relevant social, economic, legislative and religious climate in Queensland during different periods of time. The main thrust of our findings is presented in Chapter 5 which covers orphanages and residential care, Chapter 7 which covers industrial schools and detention centres, Chapter 9 which covers detention centres today, and Chapter 11 which covers legislation and departmental practice. In Chapter 12 we summarise our findings. Closed reports on the Inquiry findings with regard to St Joseph's Home, Neerkol and Karrala House have been separately provided to the Minister as they are the subject of current litigation.

THE FINDINGS AND RECOMMENDATIONS

The Terms of Reference for the Inquiry relate, in part, to all government or non-government institutions or detention centres established or licensed under the *State Children Act 1911*, the *Children's Services Act 1965* or the *Juvenile Justice Act 1992*. The brief was to determine:

(a) whether any unsafe, improper or unlawful care or treatment of children has occurred in such institutions or centres

(b) whether any breach of any relevant statutory obligation under the above Acts has occurred during the course of the care, protection and detention of children in such institutions.

In relation to (a) above, the Inquiry finds that unsafe, improper and unlawful care or treatment of children has occurred in such institutions and centres.

In relation to (b) above, the Inquiry finds that breaches of relevant statutory obligations under the above Acts have occurred during the course of the care, protection and detention of children in such institutions.

Past unsafe, improper or unlawful care or treatment

The Inquiry found that there have been incidents of unsafe, improper or unlawful treatment of children in many institutions licensed and established under the relevant Acts.

Those that may result in criminal prosecution have been referred to the Queensland Police Service. In the case of other allegations of abuse, the passage of time, the fact that a number of alleged perpetrators are now deceased and the difficulty in obtaining corroborative evidence meant that detailed findings could not be made. It has been possible , however, to make general findings on the nature of the abuse of children that took place in institutions within the Terms of Reference of the Inquiry.

The main categories of abuse identified by the Inquiry are emotional abuse, physical abuse, sexual abuse and systems abuse.

Emotional abuse

Children need care, protection and nurturing in an environment where there is trust and support. Instead, many institutions were austere places, staffed by people lacking the training and in some instances the personal capacity to provide the warmth and nurturing necessary for the healthy development of children. Until the early 1960s, most institutions were run on the basis of strict discipline, with little awareness of the developmental or even the educational needs of children. Impersonal treatment and the lack of respect for children's individuality were commonplace.

In many institutions the emotional abuse of children went far beyond neglect of their emotional needs. Behaviours on the part of some carers amounted on occasion to mental cruelty. Sometimes, demeaning, humiliating remarks were made on an almost daily basis, which had the effect of undermining the children's confidence and their sense of self-worth. Emotional abuse can be the most damaging form of abuse, and its effects were profound on the lives of many who were subjected to it.

Physical abuse

Corporal punishment was common in institutions, and was permitted under the Regulations in certain circumstances. The Inquiry found incidents of gross excesses in physical abuse in many institutions, beyond any acceptable boundary in any period. Aside from individual incidents of abuse, the Inquiry found in some institutions, at certain periods, a culture of physical punishment and brutality engendered or tolerated by the management. Westbrook, during the time when Roy Golledge was Superintendent, provided the most extreme example of such a culture.

Sexual abuse

Complaints of sexual abuse, perpetrated either by other residents, by staff, or by visitors to the institution, emerged from almost all of the institutions under consideration. In some cases, the individuals alleged to have committed the offences have already been charged and in a small number of cases, have already been dealt with. In many instances, the alleged perpetrators were long dead or could not be clearly identified.

Disclosure, difficult for any victim of sexual abuse, is even more difficult with the power imbalances and vulnerability encountered in residential or institutional care. Children are often fearful that if they tell others about the abuse it may result in further abuse or re-victimisation by the system. Many witnesses said they were disbelieved and often punished for reporting abuse.

Systems abuse

Many children historically have been the victims of the systems designed to provide care and protection for them. The Inquiry has found a range of ways that children have been harmed while within the system. Some of the harm has been caused by ignorance on the part of providers of the needs of children, some by failures in the system to monitor and track the needs of individual children, some by a lack of commitment by government to provide

adequate resources to care for the children's wellbeing, and some by a perception that children deserved no better.

One of the most obvious causes of systems abuse is the lack of funding and resourcing that has beset children's services both in the past and in the present day. Children and young people in care should receive adequate education, vocational training, physical and mental health care, leisure and recreation, contact with the community and family, and a range of programs that prepare them to function independently and risk-free upon discharge. Many children in institutions this century have not received even a basic education, let alone the range of developmental programs that would be desirable.

Resource constraints have been a perennial problem for institutions. Despite this, consecutive government departments continued to place children in institutions without regard to their capacity to provide proper care for the numbers they were receiving. The overcrowding at many denominational orphanages up to the late 1960s meant that it was impossible for children to receive adequate, individual care and attention.

A recognition of the relationship between the Department and the denominations which ran the licensed institutions is essential to an understanding of how institutional care could fail children in so many respects without intervention from the Department. The levels of funding on which almost all of the denominational institutions operated were patently insufficient to allow the provision of proper individual care. Yet the Department continued to place children in those institutions because they provided a cheap means of lodging children for whose care it was responsible, and it was able to use as justification the fact that the children were, after all, in Christian care. The churches, for their part, acquiesced in this undiscriminating placement of children because of their perceived obligation to provide refuge to homeless children, however inadequate their resources might be. By doing so, they acquired an ascendancy over the Department; it was most unlikely that the Department would jeopardise its access to those placements by subjecting the institutions to scrutiny of the kind necessary to ensure that children were being cared for properly. The denominations were thus able to carry out what they considered to be their Christian mission without risk of interference from the Department. On its side, the Department maintained an irreplaceable, cheap resource, and could complacently point to the fact that the children were being raised in a Christian environment.

Another insidious form of systems abuse to which many children were subjected was the implementation of practices that led to children who had not been convicted of criminal offences serving indeterminate periods in an institution primarily for convicted children. Neglected children, or children on care and protection orders, could, with administrative approval, be transferred to 'correctional' facilities until they reached 18 years of age if it was considered that their behaviour warranted some form of treatment program or, for some boys, simply because they had reached the maximum age accepted at an orphanage.

Similarly, children committed to care and control orders because they were considered to be in 'moral danger', 'uncontrollable' or 'likely to fall into a life of vice or crime or addiction to drugs' could remain in the care of the Director at a 'correctional' institution until they reached 18 years of age. The Inquiry heard from a number of witnesses who were unjustly incarcerated for extended periods of time for little more than their personal circumstances of neglect or purported endangerment. These examples are in stark contrast to the position of sentenced children, whose period of incarceration could be no longer than two years.

Past breaches of statutory obligations

It has been found that breaches of the Regulations in relation to food, clothing, education and corporal punishment were commonplace.

Food

Inmates at institutions licensed pursuant to the *State Children Acts* were, according to the Regulations, to be given 'plain, wholesome food' in line with an approved dietary scale, a

copy of which was to be hung in the institution's dining room. The *Children's Services Act 1965* required merely the provision of 'adequate' food.

At various times both the quality and quantity of the food given to children in institutions was inadequate. Indeed, the Inquiry heard numerous complaints of hunger being commonplace, prior to the 1960s. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

Clothing

Regulations 25 and 46 of the Regulations under the *State Children Acts* provided that all inmates of an institution were to be supplied with outfits, the details of which were prescribed. Regulation 18 permitted the clothing received with children on their admission to be 'utilised for the purposes of the institution'. Section 40 of the *Children's Services Act 1965* required the provision of 'adequate' clothing.

Many of the witnesses to the Inquiry who had lived in institutions prior to the 1970s spoke of being given ill-fitting, stigmatising and insufficient clothing. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

Education

Section 37 of the *State Children Act 1911* required that children between five and 14 years of age be sent to a State school or other school approved by the Director. Regulation 9 under that Act required that school-age children in institutions be given 'secular instruction in accordance with the syllabus of work required by the Department of Public Instruction in State schools' (i.e. a standard education). The *Children's Services Act 1965* (section 40) required the person in charge of an institution to secure for each child 'adequate education … of such a type and form as is approved by the Director or, in the absence of such an approval, as is in the best interests of such child'.

One of the strongest impressions left on the Inquiry was the poor quality of education received by many of the witnesses. A number were illiterate, or close to it, despite having spent their childhoods in the care of the State; others who had, in their adult lives, displayed significant ability had not been able to achieve a higher level than Scholarship. The limitation on their education was one of the most profound and enduring losses suffered by former residents. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

Discipline and corporal punishment

Regulation 23 of the Regulations under the *State Children Act 1911* empowered the Superintendent of an institution to punish any State child guilty of misconduct. All complaints and punishments were to be entered in a punishment book. Corporal punishment was, pursuant to Regulation 24, 'to be administered as seldom as possible … only resorted to when absolutely necessary for discipline, and not for first offences unless of a grave nature'. It could be applied only in the presence of and by direction of the Superintendent. The 1966 Regulations under the *Children's Services Act 1965* reiterated the requirement that corporal punishment be used only as a last resort, and prohibited its use on girls. It could be administered only by or under the direction and supervision of the person in charge and in the presence of a suitable witness; and it could be applied only with a leather strap of a type approved by the Department over the child's trousers. Again, a punishment book was prescribed, which had to be endorsed with the details of the punishment and the reasons for its application.

The Inquiry heard evidence of many instances of harsh discipline and finds that excessive corporal punishment occurred in a number of institutions, in breach of the relevant Regulations.

How the abuse was allowed to happen

How was it that numbers of children, while under the guardianship of the State and in the care of some of our most esteemed denominational bodies, were able to be abused? This has been a difficult question to answer. There are a range of factors that have contributed. Until the early 1960s there was little understanding of the emotional needs of children, and even less understanding of the impact that harsh emotional and physical treatment has on children in later life. Ignorance played a role: both the Department and society in general believed that if children were in the care of trusted religious organisations or 'good upstanding citizens', they would be safe. There was also the lack of awareness or belief that sexual abuse could occur.

Institutions were under-funded, short-staffed and generally closed environments with limited opportunity for meaningful interaction with the local community. Isolation from the wider community and the lack of external scrutiny places an institution at high risk of harbouring abusive practices. Physical isolation also makes it difficult for professionals or relatives to visit.

Carers were often young, untrained and intimidated by the hierarchy of their organisations. The culture of the organisation (and thus acceptable practices in terms of emotional abuse and corporal punishment), was often established by the practices of senior staff, and it was their underlying values and norms that determined acceptable standards in the institution. Hierarchical structures make it difficult for young people and front-line workers to make complaints. In any event, complaints mechanisms did not exist, and there was minimal monitoring or inspection by the Department. All of these factors converged to create an environment ripe for abuse to occur.

The causes of institutional abuse are dealt with in detail in Chapter 2. They are summarised below in relation to the findings of the Inquiry in an endeavour to explain how the abuses were able to occur and to continue undetected.

The Inquiry has heard evidence about a number of large institutions where a great many children were cared for by relatively few staff. The larger the institution, the more difficult it is to avoid institution-focused care. Size leads to regimentation and 'batch living' which contributes to depersonalisation. This situation has led to a corruption of care standards.

The scant allocation of resources and support by government and society for staff and training have directly contributed to abuse of children in residential or detention settings. In many cases, institutions accepted more children than they could safely accommodate. Overcrowding was common, and often it was a challenge to meet the physical requirements of children in terms of food, clothing and warmth. The emotional and nurturing needs of children were beyond possibility, even had there been an understanding of their significance.

In some of the larger institutions, buildings housing different groups of children were physically separate, and staff and children had little contact with other sections of the institution. It was possible in these environments for abuse to be taking place in one location and for other staff and children to be unaware of its occurrence.

Historically, most positions involving the direct care of children have carried very low financial rewards and required no qualifications. This has particularly been the case in non-government organisations. The church organisations were often reliant on volunteers prepared to work long hours for minimal remuneration, such volunteers usually being drawn from the ranks of the church and apparently motivated by religious commitment.

Poor supervision and staff support have also contributed to a high-risk environment for children. Child care is difficult and challenging, and is made even more so where conditions are poor. Work hours were often extended, and a heavy workload was a consistent feature of the work of carers in orphanages, which contributed to the creation of an abusive environment. In circumstances of poor supervision, no inspections and little accountability or external advocacy for children, caregivers wielded almost unlimited power over the children.

Powerlessness has been a central feature of almost all the cases of young people being subjected to abuse in care. Children's weakness and vulnerability are characterised by their lack of power or influence, their scant knowledge of how the organisation works, and their lack of awareness of how to assert their rights or how to make complaints about those on whom they depend for the basic elements of living. Many witnesses said they had lost faith that anyone would ever take their complaint seriously.

Without standards, the monitoring of institutional practice is arbitrary and left to the discretion of the inspector or representative of the licensing authority. A consistent feature of the evidence of former staff of the Department was the virtual absence of standards and procedures prior to the 1970s, when the professionalisation of the Department largely occurred.

Historical evidence demonstrates that the Department failed to provide protection from abuse for children in residential care facilities. Its performance fell far short of the requirements outlined in the Regulations. Notwithstanding the Director's guardianship of State children, the Department appears to have ceded responsibility for the protection of children from abuse to the institutions.

Abuse, neglect and mistreatment of children today

Residential care facilities

Although the Inquiry found far fewer incidents of abuse and breaches of Regulations in contemporary institutions, there were some. There are also a number of shortcomings in the oversight, management and operation of residential care facilities today that place children at potential risk of harm.

The Inquiry found clear indicators of the risks of abuse in the areas of funding, standards monitoring and casework practice. There is a significant disparity in the way services operate, the degree to which they are monitored and supported by the Department of Families, Youth and Community Care (DFYCC) and the extent to which the children and young people in care are at risk. The Inquiry found examples where services failed to meet their obligations under the law and where services were at risk of failing to prevent abuse of children in care.

An examination of current practice in residential care in Queensland found that the Practice Standards used by DFYCC for residential care are no more than a set of principles and aspirations, unconnected to any mechanism to assess whether agencies are meeting them. Because compliance with the Standards requires resources and time on the part of both the Department and the agency, there is little incentive for either party to attend to the application of the Standards to the services.

Managers of some residential services were unsure of their rights or of the processes involved when a staff member is suspected of abusing a child in care. In all cases, the response was to 'immediately inform the Department'. Beyond this, however, there seemed to be little understanding of the rights of the agency as an employer, their obligations to protect the child, and their responsibilities to the accused staff member, other staff and the informant (where there is one).

Police checks are relied on to 'clear' staff to be employed in residential facilities for children and young people. There was very little evidence of comprehensive reference and qualifications checks or intensive interview procedures. Because of the difficulties of attracting qualified staff to work in residential care, agencies were reluctant to make it more difficult to recruit.

If a fundamental characteristic of abuse in care is its pervasiveness in the culture of the organisation and its secrecy—either between the child and the staff member, or on the part of the organisation in order to protect itself—ad hoc inspections are unlikely to be useful. It is unlikely that abuse will be detected by a 'flying visit' from an Official Visitor or a licensing officer. For abuse to be uncovered—whether it is rife through the organisation or a once-only

incident—a range of strategies need to be in place that will provide blanket coverage of the organisation and inhibit any attempts at organised abuse of residents.

There are a number of risk areas:

- A number of residential care institutions are currently isolated.
- Recruitment and selection procedures in residential care facilities are inadequate.
- There are deficiencies in the design of the physical environments in some facilities.
- The absence of clear standards creates the potential for abusive situations to occur.
- The procedures and mechanisms for reporting and managing abuse are inadequate.

The Inquiry found little evidence that the Department of Families, Youth and Community Care actively works in a systematic way to reduce the risk of abuse of children in care in residential care facilities.

Detention centres

Detention centres house large numbers of troubled children and young people. An important part of their role should be rehabilitative and diversionary, to prevent young people graduating to the adult prison system. They are failing in that role. The Inquiry found that in a number of ways they offer less to the young people incarcerated than the adult prison system does, in terms of privacy, facilities, safety and programs. The detention centres suffer from inadequate physical facilities, a lack of staff training and supervision, a paucity of programs for detainees and an over-emphasis on security.

Current practices blur essential distinctions between the operation of incentive schemes and disciplinary systems. The wide level of discretion regarding the type of 'consequences' (disciplinary measures) that can be imposed permits the response to be appropriate to the situation, but it also increases the risk of inappropriate and in some cases abusive and/or unlawful sanctions.

Detainees' visits may be restricted as a consequence of misbehaviour. Access to family and friends is essential for the wellbeing of young people in detention, and it is unacceptable that the already limited opportunity for visits may be further reduced. It also fails to comply with the general principles of juvenile justice provided in section 4 of the *Juvenile Justice Act 1992* and in particular section 4(f)(iii), which requires a child offender to 'be dealt with in a way that strengthens the child's family'.

Regulation 16(1) of the Juvenile Justice Regulations 1993 provides that a child can be separated in a locked room only if the child is ill, the child requests it, for routine security purposes in accordance with departmental guidelines, for the child's protection or the protection of other persons or property, or to restore order. The Regulation implicitly recognises the potential psychological and emotional harm that may be caused by separation in a locked room. The current practice of isolating young people suggests that its potential harm and the regulatory requirements have been confused or overlooked.

The frequency with which detainees in Queensland's juvenile detention centres are searched indicates that their dignity, privacy and psychological wellbeing are repeatedly ignored in favour of scrupulous security procedures. Searches of any kind are intrusive, embarrassing and reinforce the relative powerlessness of the person subjected to them. Unclothed searches are especially so, particularly for self-conscious adolescents, many of whom have suffered physical and sexual abuse.

The Regulations permits the use of reasonable force if necessary to carry out any of these searches. Although all centres keep a register of unclothed and body searches, the registers do not indicate if force was used. The physical restraint of a non-compliant young person to permit workers to forcibly remove his or her clothing is unacceptable. Intentional repeated

strip-searching of a detainee at random intervals is clearly in breach of section 14(3)(c) of the 1993 Regulations, which prohibits as discipline 'an act that involves humiliation, physical abuse, emotional abuse or sustained verbal abuse' .

There is a high level of consciousness among all staff in the centres about the potential for detainees to attempt to harm themselves. Despite this, all centres continue to provide ample opportunity for self-harm in shared bathrooms and in many detainee rooms.

Complaints mechanisms that exist are poorly developed and inadequate to provide meaningful data on current operations. There is little awareness of the need for monitoring and review processes in the centres. Whatever the reason, limited monitoring and inadequate complaints systems increase the chance for child abuse and neglect to occur and go unreported.

Section 215(1) of the *Juvenile Justice Act 1992* provides that a detainee or parent of a detainee may complain about any matter affecting the child. The Inquiry was unable to find a departmental procedure for general detainee complaints, although procedures exist for complaints of alleged misconduct by staff and the role of Official Visitors in receiving complaints. Thus it is not known how complaints made to departmental staff (as opposed to the Official Visitor) about general conditions such as food, clothing, access to property or visits are to be made, dealt with and recorded. The lack of such departmental procedures breaches section 215 of the Act.

Aside from the potential risks to all young people in detention centres, comment must be made on two groups of young people who are disproportionately represented in the centres and for whom there may be alternatives to incarceration. The first group are those young people on remand—almost half of all detainees at any one time—and alternative placement options are urgently required for these children. The second group are indigenous young people, who are grossly over-represented in juvenile detention centres.

The Inquiry found a number of serious shortcomings in the operation of juvenile detention centres that do not meet legislative requirements or acceptable standards. These shortcomings indicate that young people detained in detention centres today may be at risk of abuse or mistreatment, and are certainly living in physical facilities that are far inferior to adult correctional centre facilities and that fall short of the legislative requirements and the relevant UN Conventions. The current operation of these centres is unlikely to rehabilitate young offenders, and is more likely to increase their disaffection with society and their risk of subsequent offending.

Deficiencies in the current legislation

The current legislative framework for children in institutions consists of three major pieces of legislation. The legislative base for the provision of residential care services for children and young people is provided by the *Children's Services Act 1965*. This legislation will be superceded by the *Child Protection Act 1999*, which was assented to on 30 March 1999 but has not yet been proclaimed. For juvenile detention centres, the legislative base is provided by the *Juvenile Justice Act 1992*.

There are a number of important shortcomings in the current legislative provisions for care and protection of children in institutions:

- There is no legislatively mandated reporting process for abusive incidents involving children and young people in residential care and in detention centres.
- There are no legislative requirements for DFYCC to conduct regular supervisory or inspection visits to residential care services or to detention centres.
- There is no legislative requirement that DFYCC collect information relating to the abuse of young people in out-of-home and institutional care.
- There is no legislative provision for advocacy services for young people in residential care or in detention centres.

- There is no provision in legislatively prescribed licensing requirements that residential care services be subject to regular review processes or evaluations, or for records of these processes to be considered in licensing decisions.

Consequences for victims of abuse

There is still a great deal that is not understood about the outcomes of child abuse. It is not an easy subject to study and it is often difficult to disentangle the effects of abuse from the effects of other factors such as disrupted families. There is, however, a general consensus that outcomes are often profoundly negative.

The relationships of abuse victims may be dysfunctional. Low self-esteem and self-worth, compounded by a lack of education, can develop into mental health problems that further limit the victim's capacity to achieve his or her human and economic potential. Witnesses described a number of enduring effects of their institutional experiences, including a lack of self-esteem, an inability to trust others, and relationship problems exacerbated by anger and aggression. Striking features of witnesses' evidence were suicide attempts and relationship failures. For a number of witnesses, admission to an institution started a process of institutionalisation that ended in gaol.

The Inquiry recognises that it is not often possible to link a specific instance of institutional abuse to a specific problem faced by an individual in later life. However, there is little doubt that children who have been exposed to severe or prolonged abuse are facing long-term problems that will disrupt or damage the rest of their lives, and affect all those significant others around them.

The effects of childhood maltreatment cannot be categorised easily and outcomes can vary a great deal among survivors according to the type of abuse, its duration, the child's relationship with the abuser, and resilience factors that may have gone some way towards protecting the child.

Although the following sections are arranged according to the different forms of abuse, this is not meant to understate the complexities involved in discussing the outcomes of child abuse, nor the compounding effects on children who experience a range of abuses. There is substantial overlap between different types of abuse; children that experience one form of abuse are far more likely to experience other forms.

Physical abuse

There are seven main outcomes of physical abuse: aggressive and violent behaviour, non-violent criminal behaviour, substance abuse, self-injurious and suicidal behaviour, emotional problems, interpersonal problems, and academic and vocational difficulties (Malinosky-Rummell & Hansen 1993).

There is now little doubt about the relationship between childhood physical abuse and emotional and psychological problems in later life. These problems include anxiety, depression, hostility, paranoid thoughts, psychosis and dissociation disorders (see, for example, Fox & Gilbert 1994; Middleton & Butler, in press). Adolescents and adults who exhibit violent behaviours have often been abused as children. Such violent behaviours can include violence towards people inside the family, violence toward authority figures, homicidal behaviours, fighting or violent criminal acts, and rape (Riggs et al. 1990; Straus et al. 1980; Kroll et al. 1985; Rosenbaum & Bennett 1986; Pollock et al. 1990).

A number of behavioural problems are related to corporal punishment, such as sleep disturbances, temper tantrums, aggressive behaviour, nightmares, headaches, frequent crying, anger and withdrawal. Involuntary urination or enuresis are common experiences for children who suffer corporal punishment (Hyman 1987).

Sexual abuse

Child sexual abuse is now widely accepted as causing mental health problems in adult life. Specifically, child sexual abuse has an impact on social, sexual and interpersonal functioning, and affects the child's developing capacities for trust, intimacy, mastery of their world, and sexuality. When discussing outcomes of child sexual abuse, distinction should be made between severe physically intrusive forms of sexual abuse involving penetration, and other less intrusive forms such as touching or exposing genitalia to a child. In general, intrusive forms of abuse result in more profoundly negative consequences.

It is now well documented that sexually abused children experience difficulties at school with academic performance and behaviour. These difficulties are likely to have a negative influence on later educational attainment, and restrict the skills and discipline necessary to maintain an effective role in the work force (Tong et al. 1987; Cohen & Mannarino 1988; Einbender & Friedrich 1989).

Child sexual abuse involves a breach of trust or an exploitation of vulnerability, and frequently both. Sexually abused children not only face an assault on their developing sense of sexual identity, but a blow to their construction of the world as a safe environment and their developing sense of others as trustworthy. In those abused by someone with whom they had a close relationship, the impact is likely to be all the more profound.

A history of child sexual abuse is reported to be associated with insecure and disorganised attachments (Alexander 1993; Briere & Runtz 1988; Jehu 1989), and increased rates of relationship breakdown (Beitchman 1992; Bagley & Ramsey 1986; Mullen et al. 1988 ; Mullen et al. 1994). Poor self-esteem in adults has also been shown to be associated with child sexual abuse, and is thought to be an outcome of the more intrusive forms of abuse involving penetration (Romans et al. 1996). Child sexual abuse also affects the mental health of many survivors (Briere & Runtz 1988; Winfield et al. 1990; Bushnell et al. 1992; Mullen et al. 1993; Romans et al. 1996 and 1997; Silverman et al. 1996; Bucky & Dallenberg 1992; Spanos 1996).

Emotional abuse

Although emotional abuse has the most destructive consequences for children (Garbarino & Vondra 1987), it is rarely assessed in studies of childhood physical abuse and neglect (Rosenburg 1987). In fact, it has been well documented that physical and/or sexual abuse usually occur alongside emotional abuse (Egeland et al. 1983; Garbarino & Vondra 1987), so it is difficult to assess the severity of the consequences of specific emotional abuse. There is, however, a developing agreement that emotional maltreatment is a fundamental cause of negative developmental outcomes for children (Garbarino 1990; Navarre 1987).

For children exposed to psychological abuse over some years, the resulting inability to develop good relationships with others creates a vulnerability to further abuse. It may result in exposing the child to further risk from carers who do not understand or respond well to the child's dysfunctional behaviours.

CONCLUSION

Over the years significant numbers of children in the care of the State in government and non-government institutions have been subjected to repeated physical, emotional and sexual abuse. The scope and scale of the abuse varied among institutions and varied at different times by different perpetrators. Not all institutions were involved, nor were all children in care abused. However, some key commonalities among the abuses included an abuse of power, a betrayal of trust, a reluctance of people in authority to acknowledge or deal with the abuse, and an official response which showed more concern for the protection of the institution and the abusers than for the safety of the children, particularly where cases of sexual abuse have not been referred to the police for prosecution.

Aside from these abuses, we found in a number of institutions a failure to provide for the basic human needs of children. Many children in institutions received limited education, little

instruction in life skills and an emotional coldness that had a profound impact on their later lives. We acknowledge that most non-indigenous children in the orphanages had come from backgrounds with serious problems. Consistently, we found that the impact of their placement in orphanages and their experiences in them have affected their lives in a profoundly negative way. We found little to convince us that historically the government, through the Department, had any vestige of a system in place that would enable it to properly monitor the care of children in institutions.

There have been significant improvements over the past two decades through professionalisation of the Department and the staff of institutions, and the implementation of improved systems. However, in reviewing contemporary detention centres and residential care facilities it is clear that there remain a number of deficiencies in the current systems and programs, and we have concluded that there is still potential risk of abuse to children in care. Adequate accountability systems are not in place, in institutions or on the part of the Department, to ensure that children are protected, and to ensure that where abuse occurs it is appropriately dealt with. Improving monitoring and accountability is the centrepiece of our recommendations for the future.

In making our recommendations we conclude that although it was individuals who perpetrated each act of abuse, they alone cannot shoulder the whole responsibility. Some measure of responsibility must be taken by those to whom the abuses were reported and who did not act, those in charge of the institutions who did not have sufficient safeguards in place to protect the children, those members of religious organisations who turned a blind eye, the staff and the management of the Department of Children's Services who did not adequately monitor the children in their care, successive State Governments that have not sufficiently valued children to adequately resource the Department entrusted with their care, and society, which ignored or accepted what happened to children in the care of the State. As a State, we must face up to past wrongs and make proper redress, and ensure that when children are in our care we do them no harm.

RECOMMENDATIONS OF THE INQUIRY
(in the order that they appear in the report)

Recommendation 1 (Chapter 5 p. 98)

That the Department continue to give effect to the recommendation of the *Daffen Report 1998* that funding to Petford Training Farm as a residential facility for young people be terminated.

Recommendation 2 (Chapter 5 p. 106)

That the Department undertake a project similar to *Connecting Kin*, developed by the NSW Department of Community Services in 1998, to identify the repositories of information relevant to the lives of former State wards in Queensland.

Recommendation 3 (Chapter 5 p. 106)

That the Department notify all non-government organisations that have been involved in the care of children in Queensland that it is willing to accept any surviving records relating to State wards and that it will retain those records and provide the individuals and families concerned with access to them.

Recommendation 4 (Chapter 6 p. 118)

That the Queensland Government increase the budget of the Department by $103 million to permit it to meet the national average per capita welfare spending for children, and agree to maintain the increase in line with the national average. The additional resources should focus on the prevention of child abuse through supporting 'at risk' families, respite care, parenting programs and other early intervention and preventative programs for high-risk families.

Recommendation 5 (Chapter 8 p. 189)

That there be a concerted whole-of-government effort to reduce the gross over-representation of indigenous children in juvenile detention centres.

Recommendation 6 (Chapter 8 p. 191)

That alternative placement options be developed for young people on remand in order to reduce the number placed in juvenile detention centres.

Recommendation 7 (Chapter 9 p. 210)

That the Department review the practice of unclothed searches with a view to reducing their use, and that detailed documenting (date, time, reason and process used) of every such search be made.

Recommendation 8 (Chapter 9 p. 215)

That the Department ensure:

- contact with family and friends is treated as a basic entitlement of all detainees, essential to their psychological wellbeing and successful reintegration, and that it should not be apportioned according to behaviour
- contact with family and friends is actively encouraged, and that efforts are made to ensure that visits are relaxed and positive for detainees and visitors alike
- contact by detainees with partners and 'significant others' is given the same status as that given to parents and siblings
- procedures that deny a young person contact and support from their family are examined and eliminated unless a substantial case can be made for their retention
- visiting times are varied to accommodate the needs of working parents, shiftworkers and those with small children.

Recommendation 9 (Chapter 9 p. 216)

That the Department explores mechanisms for increasing community involvement in juvenile detention centres.

Recommendation 10 (Chapter 9 p. 218)

That the Department work closely with Queensland Health to establish adequate, high quality mental health services for juvenile detainees, staffed by in-house specialised mental health personnel with whom a child and adolescent psychiatrist and allied mental health staff can consult part-time.

Recommendation 11 (Chapter 9 p. 224)

That the Department and Education Queensland jointly review the allocation of special education resources for children in institutions and prepare a detailed report to both Ministers, by 31 December 1999, on the current availability and any gaps, as well as a clear plan for rectification.

Recommendation 12 (Chapter 9 p. 227)

That the Department ensure that all young people in detention centres, whether sentenced or on remand, have access to:

- a range of programs that will both engage them and be of future vocational benefit
- community-based educational, vocational and related services to assist reintegration and to help reduce the isolation and separation felt by detainees
- appropriate recreational facilities and sporting instruction as central components of programmed activities, recognising the importance of sport as a factor in achieving reintegration and reducing recidivism.

Recommendation 13 (Chapter 9 p. 236)

That the closure of Sir Leslie Wilson Youth Detention Centre be accomplished as planned by the end of 2000, or before, and that the refurbishment of John Oxley and Cleveland Youth Detention Centres proceed as a matter of urgency.

Recommendation 14(Chapter 9 p. 236)

That the Minister for Families, Youth and Community Care establish an expert working group to provide advice regarding options available as an alternative to the construction of a proposed new juvenile detention centre at Wacol.

Recommendation 15 (Chapter 9 p. 237)

That the Department implement in full the detailed recommendations of the consultant responsible for the review of juvenile detention centres, contained in Appendix 13.

Recommendation 16 (Chapter 11 p. 258)

That legislation be enacted to make mandatory the reporting of all abusive situations that come to the attention of departmental employees and persons employed in residential care facilities and juvenile detention centres.

Recommendation 17 (Chapter 11 p. 258)

That requirements for the Department to conduct regular inspection and monitoring of residential care facilities and juvenile detention centres be specified in legislation.

Recommendation 18 (Chapter 11 p. 258)

That the Department have a legislatively imposed responsibility to collect information relating to abuse of children and young people in residential care facilities and juvenile detention centres.

Recommendation 19 (Chapter 11 p. 258)

That the provision of advocacy services for young people in residential care facilities and juvenile detention centres be required by legislation.

Recommendation 20 (Chapter 11 p. 258)

That legislation be enacted to require that licensing of residential care facilities be subject to an independent written evaluation.

Recommendation 21 (Chapter 11 p. 261)

That by December 2000 the Department:

- assess the needs across Queensland for residential care
- review the effectiveness of current models of residential care (e.g. family group homes compared to larger institutions such as BoysTown)
- develop criteria for equitable distribution of facilities and appropriate models of care
- develop medium- and long-term plans for future development of residential care, taking into account the distribution and needs of children throughout the State
- review funding and provision of residential services for indigenous young people to ensure quality of services and cultural appropriateness.

Recommendation 22 (Chapter 11 p. 262)

That in order to ensure effective links between standards of care, service agreements, quality assurance, licensing and legislative requirements for residential care, the Department:

- review the *Practice Standards for the Conduct of a Licensed Residential Care Service* to ensure consistency with the statement of standards outlined in the *Child Protection Act 1999* and develop clear performance indicators that are incorporated into service agreements
- develop a system of independent external accreditation based upon the standards required under the Act
- require that all residential care facilities be subject to independent evaluation as a condition of being granted a licence or renewal of a licence.

Recommendation 23 (Chapter 11 p. 263)

That the Department establish a short-term residential facility to enable proper and comprehensive assessments when children are first admitted to care.

Recommendation 24 (Chapter 11 p. 264)

That the Department develop and implement an information system that records individual complaints and trends in institutional abuse.

Recommendation 25 (Chapter 11 p. 264)

That amendments be made to the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996* to ensure the independence of the office of Children's Commissioner, and provisions be made for its attachment for administrative support services to the Premier's Department.

Recommendation 26 (Chapter 11 p. 265)

That the office of the Children's Commissioner be strengthened by:

- investing it with the role of Independent Inspector of residential care facilities and juvenile detention centres with wide powers of inspection in relation to such matters as

the treatment of residents, preparation for release, morale of residents and staff, quality of health care and education, physical facilities and management

- empowering the Commissioner to conduct Inquiries into matters affecting children and young people including the authority to investigate and resolve complaints about the provision of services to children and young people
- establishing a comprehensive research function to enable research to be conducted into all matters relating to the rights, interests and wellbeing of children and young people in residential facilities and juvenile detention centres
- providing the Commissioner with the power to monitor the role of the Department in overseeing the care of young people in residential facilities and detention centres.

Recommendation 27 (Chapter 11 p. 265)

That there be a Children's Services Appeals Tribunal constituted as a separate entity to the Children's Commission whose procedures are inquisitorial rather than adversarial in nature.

Recommendation 28 (Chapter 11 p. 266)

That there be a review of the Official Visitors' program focusing on the legislative base, policy and procedural guidelines, actual practice, and effectiveness of the service.

Recommendation 29 (Chapter 11 p. 266)

That the Official Visitors' program be maintained and extended with a view to providing a comprehensive monitoring function of all residential facilities for children and young people, including those not funded by the State but which, nevertheless, provide a similar service and including juvenile detention centres.

Recommendation 30 (Chapter 11 p. 266)

That visits from Official Visitors be regular and frequent, and the number of Visitors reflect the size of the client base.

Recommendation 31 (Chapter 11 p. 266)

That Official Visitors be empowered to act as advocates for children and young people in care, by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances.

Recommendation 32 (Chapter 11 p. 267)

That Official Visitors be provided with complete orientation and training in alternative care practice, standards of residential care, advocacy issues and practice, and developing trusting relationships with young people.

Recommendation 33 (Chapter 11 p. 267)

That Official Visitors be given access to relevant information about children and young people in care, and that they be bound by the same rules of confidentiality as other Commission and departmental staff.

Recommendation 34 (Chapter 11 p. 269)

That by December 2000 the Department develop and implement policies which ensure that:

- there is a range of easily accessible, confidential complaints mechanisms for children
- children making complaints are protected and any worker about whom a child has made a serious complaint is separated from children in the facility, without loss of pay and other employment conditions, pending the outcome of the investigation of the complaint
- a rapid response to complaints is made and the action taken is documented
- senior officers of DFYCC or other personnel independent of the service with substantial experience in matters relating to child abuse carry out the investigation
- all allegations of abuse in out-of-home care are made the subject of mandatory reporting by institutional staff and are notified to the Children's Commissioner and the Office of the Director-General, DFYCC
- all serious complaints result in review processes to identify systemic problems and to provide recommendations for improvement
- all documentation relating to complaints or allegations of abuse is subjected to external review and audit, to ensure that required procedures have been followed
- a central database of caregivers is established to identify patterns of complaints and trends in institutional abuse.

Recommendation 35 (Chapter 11 p. 270)

That by December 2000 the Department prepare:

- detailed and standardised procedures for record-keeping that must be maintained by residential facilities, detention centres and the Department
- quality assurance mechanisms, including monitoring and review processes, that can measure whether appropriate standards are being maintained, that individual cases of abuse are detected and dealt with, and whether staff have the necessary conditions to work effectively
- detailed time-limited plans for their implementation across residential institutions caring for children.

Recommendation 36 (Chapter 11 p. 273)

That by December 2000 the Department:

- review issues affecting field staff responsible for children in care, including excessive caseloads, inadequate personal and professional supervision, high turnover, insufficient resources and training, and implement measures to address them
- establish the minimum requirement to operate each institution and provide adequate funding to ensure that the facilities can operate safely
- require through service agreements and service standards for residential services that staff are recruited through transparent merit selection processes, that clear human resources development and management standards are applied and that these standards be part of a contract, review and evaluation process. This must include, as a minimum, clear job descriptions and regular progress and performance monitoring of staff
- require scrupulous screening of all staff and other people in regular contact with children in residential care facilities and juvenile detention centres, not only through police checks (including fingerprints and records of charges laid) but also extensive interviews to ensure their suitability to be in contact with children or young people in care or detention
- require that criminal history and Child Protection Register checks be conducted on an ongoing basis, at a minimum of five-yearly intervals, for all residential care and juvenile detention centre staff

- address staff training requirements (initial and ongoing) for residential care services by the application of Service Standards and provision of training for all service providers
- require that an accredited core training program be completed by all residential care workers and that orientation programs to clarify staff roles and expectations be conducted, as well as refresher training programs for staff at regular intervals
- review staffing and supervision arrangements within detention centres, with risk assessment procedures applied to determine appropriate supervisory arrangements and the optimum staffing balance of permanent to casual staff to provide cost-effective service delivery by experienced staff, while minimising risk.

Recommendation 37 (Chapter 12 p. 288)

That the Queensland Government and responsible religious authorities issue a formal statement acknowledging the significant harm done to some children in Queensland institutions licensed under the *Infant Life Protection Act 1905*, the *State Children Act 1911*, the *Children's Services Act 1965* and the *Juvenile Justice Act 1992*, formally apologise for that harm and make a commitment to prevent further abuse.

Recommendation 38 (Chapter 12 p. 288)

That the Queensland Government and relevant religious authorities organise a reconciliation event for former victims of abuse in orphanages and detention centres after consultation with them.

Recommendation 39 (Chapter 12 p. 288)

That the Queensland Government and responsible religious authorities establish principles of compensation in dialogue with victims of institutional abuse and strike a balance between individual monetary compensation and provision of services.

Recommendation 40 (Chapter 12 p. 288)

That the Queensland Government and responsible religious authorities fund an independent 'one stop shop' for victims of abuse in institutions that provides a range of services such as:

- ongoing counselling for victims and their families
- facilitation of educational opportunities including literacy programs
- advice regarding access to individual records, documents and archival papers
- specialised counselling services for indigenous victims of abuse
- assistance to former child migrants for reunification with their families.

Recommendation 41 (Chapter 12 p. 288)

That the Department develop transitional programs to prepare young people in the care of the State for independent living and help them to make the transition by providing assistance to gain employment, education and housing.

Recommendation 42 (Chapter 12 p. 288)

That the Queensland Government establish a process for the implementation and review of the recommendations of this Inquiry, requiring annual progress reports to Parliament on the implementation of recommendations over the next two years.